CMS Region 7 Updates – 11/06/2018

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New Medicare Card Updates

New Medicare Card: Destroy the Old Card

Remind Medicare patients that when they get their new Medicare cards, they should destroy the old red, white, and blue Medicare cards but not their Social Security, Medicare Advantage plan, or drug plan cards. If they belong to a Medicare Advantage plan or a Medicare drug plan (Part D), they should continue to use these cards when they get health care services or fill a prescription.

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Medicare Diabetes Prevention Program (MDPP)

New Guidance Released: Medicare Diabetes Prevention Program (MDPP) Beneficiary Eligibility Verification

Medicare beneficiaries must meet six eligibility criteria to have coverage of MDPP services. One of these criteria is that the individual have Medicare Part B coverage through Original Medicare (Fee-for-Service) or a Medicare Advantage (MA) plan.

The Centers for Medicare and Medicaid Services (CMS) has released guidance for MDPP suppliers on how to verify a beneficiary's Medicare coverage to determine whether or not the beneficiary is eligible for coverage of MDPP services.

A full list of MDPP beneficiary eligibility requirements, including those criteria that can be self-reported, can be found in the MDPP Beneficiary Eligibility Fact Sheet.

New Guidance Released: Updates to the MDPP Payment Rates for Calendar Year 2019 (CY 2019)

The CY 2018 MDPP payment rates were established in the CY 2018 Medicare Physician Fee Schedule final rule. This rule also established that MDPP payment rates will be adjusted each calendar year using the Consumer Price Index. The updated payment rates for CY 2019 can be found here.

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Medicare Diabetes Prevention Program: New Covered Service

November is National Diabetes Month. The 2019 Medicare & You Handbook includes information on the Medicare Diabetes Prevention Program (MDPP), a new Medicare-covered service. Help your patients prevent or delay Type 2 diabetes and understand their treatment options.

For More Information:

- Review materials from the September 26 Medicare Learning Network call and the beneficiary brochure
- Become familiar with beneficiary eligibility criteria and coverage; screen at-risk patients for eligibility
- Access the MDPP Supplier Map or view a list of all current MDPP suppliers; refer eligible patients to a nearby MDPP supplier
- Visit the MDPP Expanded Model webpage

MDPP is a new program that is still ramping up. If you do not see an organization that offers services in your community, keep checking the list. New MDPP suppliers are added to the list on a regular basis.

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Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the September 26 call on the Medicare Diabetes Prevention Program: New Covered Service. Learn about the service, eligibility requirements, and how to refer your patients.

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ACA/Marketplace Updates

Premiums on the Federally-facilitated Exchanges drop in 2019

Administration's actions provide some relief from skyrocketing premiums

The Centers for Medicare & Medicaid Services (CMS) announced that the average premium for second lowest cost silver plans (SLCSP) for the 2019 coverage year will drop by 1.5 percent, the first time average premiums have dropped since the implementation of the Federally- facilitated Exchange in 2014. Tennessee being the largest with a 26.2 percent reduction. These premium reductions along with increased issuer participation strongly suggest that the numerous actions taken by the Trump administration to stabilize the market are working.

"President Trump's Administration took action to address the skyrocketing price of health insurance, and now we are starting to see the results," said CMS Administrator Seema Verma. "Despite predictions that our actions would increase rates and destabilize the markets, the opposite has happened. The drop in benchmark plan premiums for plan year 2019 and the increased choices for Americans seeking insurance on the exchanges is proof positive that our actions are working. While we are encouraged by this progress, we aren't satisfied. Even with this reduction, average rates are still too high. If we are going to truly offer affordable, high quality healthcare, ultimately the law needs to change."

After the Patient Protection and Affordable Care Act (PPACA) regulations took effect in 2014, average individual market premiums more than doubled from $2,784 per year in 2013 to $5,712 on HealthCare.gov in 2017, an increase of $2,928 or 105 percent.[1]In the HealthCare.gov states, between 2017 and 2018, the average premium for the second-lowest cost silver plan increased by 37 percent. Between 2016 and 2017, the hike in average premiums was 25 percent.

In addition, since 2016 we have seen many individual market issuers drop out of the Exchange in states using the healthcare.gov platform. For example, for the 2016 plan year, there were 237 medical qualified health plan (QHP) issuers operating within Exchanges on the federal platform, by the next year there were only 167 medical QHP issuers, which is approximately a 30 percent decrease. By 2018, more than half of U.S. counties on the federal platform had only one issuer, leaving millions of consumers with little to no choice.

At President Trump's direction, CMS took immediate action to address market stability issues and to improve the performance of the Federally-facilitated exchanges. On Inauguration Day, President Trump issued an executive order to eliminate overly-burdensome regulations. Within a month of Inauguration Day, CMS proposed a market stabilization rule, and over the past year and a half, CMS has used its waiver authority to approve reinsurance programs in seven states, resulting in lower premiums.

As a result, for this upcoming Open Enrollment, Americans will, on average, experience lower premiums on health plans purchased on the federal exchange. There are 23 more medical QHP issuers for 2019 than were participating during open enrollment in 2018 and 29 current medical QHP issuers are expanding their service area into more counties. The number of counties with only one insurer has dropped from 56 percent in 2018 to 39 percent in 2019, and only five states will have only one insurer, compared to ten in 2018.

Each year, CMS certifies plans available for sale on the HealthCare.gov platform. As defined in the PPACA, a qualified health plan (QHP) is an insurance plan that is certified by CMS to meet statutory requirements, including benefits, established limits on cost sharing, and other requirements outlined within the application process. CMS gathers rate and premium information from issuers seeking certification to participate on Healthcare.gov.

To determine the year-over-year changes, CMS analyzed Exchange individual plan year 2019 premium data submitted as of September 28, 2018, as part of the QHP certification process.

Average premiums were then weighted, based on 2018 Exchange enrollment data. Data is subject to change due to plan withdrawals.

To see the full table of average premiums, click here: https://www.cms.gov/sites/drupal/files/2018-10/10-11-18%20Average%20Monthly%20Premiums%20for%20SLCSP%20and%20LCP%202016-2019_0.pdf

1 https://aspe.hhs.gov/pdf-report/individual-market-premium-changes-2013-2017

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Federal Health Insurance Exchange 2019 Open Enrollment

The Federal Health Insurance Exchange (also known as the Marketplace) Open Enrollment Period runs from November 1, 2018 to December 15, 2018, for coverage starting on January 1, 2019. Similar to last year, the Centers for Medicare & Medicaid Services (CMS) is taking a strategic and cost-effective approach to inform individuals about Open Enrollment, deliver a smooth enrollment experience, and use consumer feedback to drive ongoing improvements across the Exchange platform. Consumers can visit HealthCare.gov and CuidadodeSalud.gov to preview 2019 plans and prices before Open Enrollment begins.

Key Updates and Enhancements to Healthcare.gov for the 2019 Open Enrollment

Streamlined Application Visual Refresh

CMS remains committed to improving the customer experience, this year the streamlined application on HealthCare.gov was refreshed based on feedback and testing. The refreshed application that will be available for some consumers will provide better content, improved help information integrated throughout the application, and enhanced mobile optimization. CMS will continue to make enhancements to the application based on feedback and testing.

Find Local Help Enhancements

The Find Local Help tool on HealthCare.gov has been redesigned this year based on feedback from consumers, agents and brokers. This year, consumers will be able to filter agents and brokers by their minimum years of participation on the Federal Exchanges. Additionally, for the first time, individuals will be able to search for a specific agent or broker by entering their first or last name. Find local help is a tool that allows consumers to search by city and state or ZIP code to see a list of local people and organizations who can help them enroll in coverage.

Improved plan information

CMS also added improved content on Health Savings Account (HSA) eligible high deductible health plans (HDHPs) to make it easier for consumers to search for and identify HSA-eligible HDHPs. In addition, HealthCare.gov now includes information on if a particular plan covers abortion services outside of exceptions for rape, incest, or if the pregnancy is determined to endanger the woman's life.

Consumer Tools and Support

Window Shopping

On October 26, 2018, CMS launched updates to window shopping (the "See plans & prices" page on HealthCare.gov) which allow consumers to preview 2019 plans and prices before Open Enrollment begins. As in previous years, window shopping lets consumers browse plans without logging in, creating an account, or filling out the official application. Starting November 1, consumers can log in to HealthCare.gov and CuidadodeSalud.gov or call 1-800-318-2596 to fill out an application and enroll in a 2019 Exchange health plan.

Consumer Call Center

The Call Center is often the front line of assistance for consumers as they apply for coverage and compare plan options. Last year, CMS' Call Center staffing peaked at 10,000 people during Open Enrollment. CMS plans to have the same amount of staff this year. During last year's Open Enrollment, consumer satisfaction rate was at an all-time high – averaging 90 percent – throughout the entire Open Enrollment Period. In order to help prepare the Call Center representatives to handle high consumer demand, CMS will continue providing extensive training to Call Center staff prior to Open Enrollment and weekly refreshers throughout the Open Enrollment Period.

In addition to the Call Center, in-person assistance will continue to be available to help consumers with enrollment. This includes local agents and brokers, Certified Application Counselors, and federally-funded Navigators.

Help on Demand

CMS will continue to offer the "Help On Demand" services for agents and brokers. This service allows consumers to choose to have an agent or broker in their area contact them directly for assistance while they're available. For registered agents and brokers, this allows them to set times when they're available and then reach out to consumers who expressed interest in needing help applying and enrolling.

For more information, visit: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html

Financial Assistance

Premium tax credits will be available in 2019 for individuals who qualify. Consumers can continue to use Exchange coverage and take advantage of its benefits, including premium tax credits. Plans available from insurance companies will continue to reflect reduced copayments, coinsurance, and deductibles for eligible consumers.

Quality Rating System (QRS) Star Ratings Pilot

CMS is conducting a third year of the QRS pilot program to test consumer reaction to the public display of health plan quality rating information during the 2019 Open Enrollment Period. The QRS Pilot Program displays quality ratings (or "star ratings") for some health plans on HealthCare.gov. Each rated health plan has an overall quality rating of one to five stars, which accounts for member experience, medical care, and health plan administration.

CMS extended the QRS Star Ratings pilot this year to three additional states. In addition to Virginia and Wisconsin, the third pilot year will be conducted in Michigan, Montana and New Hampshire. The pilot testing helps CMS analyze the impact of QRS star ratings on consumer behavior, with the ultimate goal of providing consumers with the information they need to compare plans based on quality and pick a plan that best meets their needs.

For more information, visit: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-QRS-QHP-Survey.pdf

Small Business Health Options Program (SHOP)

Similar to last year, for enrollment in SHOP Exchanges using the Federal platform, employers will be able to enroll directly with an issuer, or with a SHOP-registered agent or broker. HealthCare.gov provides information to help assist employers looking to enroll and SHOP-registered agents and brokers assisting consumers with SHOP coverage.

Re-enrollment Process

Similar to previous years, consumers who are currently enrolled in a plan will receive notices from the Marketplace prior to November 1 about the upcoming the Open Enrollment Period. These notices provide consumers with the dates for this year's Open Enrollment and the importance of returning during this time to update their application and actively re-enroll in a plan for 2019, as well as customized messaging for their situation, such as if they're at risk of losing tax credits. Consumers also receive notices from their current issuer with important information about premiums, coverage and benefit changes, and plan availability for 2019.

Consumers who are currently enrolled are encouraged to come back and update their information, shop, and pick a plan that best suits their health care needs before the December 15 deadline. Similar to Medicare's Open Enrollment Period, consumers who miss the deadline to enroll in a plan of their choice will not be able to make any plan changes until the next coverage year unless they qualify for certain Special Enrollment Periods.

The majority of consumers whose plan isn't available in 2019 will be automatically re-enrolled into a plan from a different issuer to avoid a gap in coverage – these consumers will need to pay their premium for January in order for this coverage to begin. Consumers whose issuer isn't offering their plan in 2019 are eligible for a Special Enrollment Period due to losing coverage and have the opportunity to choose a different plan.

- **Automatic Re-enrollment:** As in previous years, CMS will automatically re-enroll consumers that don't actively re-enroll by December 15 into their same or similar plan, and if that is not available, another plan with a different insurance company. The Marketplace will send a notice to those consumers that were automatically re-enrolled.

- **Plans No Longer Available:** Consumers whose 2018 issuer does not have a plan available to them for 2019 will receive a discontinuation notice from their current issuer by the start of Open Enrollment. Those consumers may also receive a letter from the Marketplace notifying them that they have been matched with an alternate plan from a different issuer to help avoid a gap in coverage. These consumers generally will need to pay their premium for January in order for their 2019 coverage to begin. Consumers are not under any obligation to stay with their new plan and are encouraged to take action and choose a plan by December 15.

To see examples of consumer notices, visit: https://marketplace.cms.gov/applications-and-forms/notices.html

Marketing and Outreach

Similar to last year, CMS plans to spend $10 million on marketing and outreach for the upcoming Open Enrollment Period. Last year's Open Enrollment Period was the agency's most cost effective and successful experience for HealthCare.gov consumers to date. CMS will continue to use similar marketing tactics from last year and focus funding and attention on the most strategic and efficient ways to reach consumers. This year's outreach and education campaign will target people who are uninsured as well as those planning to reenroll in health plans, with a special focus on young and healthy consumers. CMS committed resources to proven high impact, low cost digital outreach efforts including short YouTube videos, social media, and mobile and search advertising.

CMS will also continue to use direct response methods including email, text messaging and autodial messages. Targeted email has proven to be the most cost efficient and effective way to reach consumers. As part of this effort, CMS will send most consumers emails throughout each week, with increasing frequency as the deadline approaches. CMS will also reinforce educational messaging through ongoing text messages and provide reminder calls encouraging consumers to take action before the December 15 deadline.

HealthCare.gov Operations

HealthCare.gov Scheduled Maintenance Windows

Every year, CMS establishes scheduled maintenance windows that provide periods of time when CMS and its partners can make updates or resolve issues. Maintenance will only occur within these windows when deemed necessary to provide consumers with a better shopping experience. Consumer access to HealthCare.gov may be limited or restricted when this maintenance is required. Regular scheduled maintenance will continue to be planned for the lowest-traffic time periods on HealthCare.gov, including Sunday mornings.

The purpose in scheduling these times is to minimize any consumer disruption. Like other IT systems, these scheduled maintenance windows are how CMS updates and improve our system to run optimally and are the normal course of business.

For more information on the scheduled and actual maintenance times, visit: https://marketplace.cms.gov/technical-assistance-resources/healthcaregov-maintenance-windows.pdf

HealthCare.gov Waiting Rooms

Similar to previous years, CMS may deploy a "waiting room" for some consumers who are logging in or creating an account on HealthCare.gov if website traffic becomes high enough to impact the consumer experience. The waiting room is one tool CMS utilizes to optimize a consumers' experience because it allows CMS to control the volume of users on healthcare.gov resulting in better performance of the website. If they are in a waiting room, consumers will see a message asking them to stay on the page. The waiting room will refresh when a consumer can continue to apply and enroll with a smooth experience.

Additional Resources

Weekly Enrollment Snapshots Similar to previous years, CMS plans to release weekly enrollment snapshots throughout the Open Enrollment Period.

2019 Health Insurance Exchange Premium Landscape Issue Brief The view the U.S. Department of Health and Human Services 2019 Health Insurance Exchange Premium Landscape Issue Brief, visit: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2019-federal-health-insurance-exchange

2019 Plan Landscape Data For more information on 2019 individual and family health plans available in the Federal Health Insurance Exchange, visit: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

2019 Health Insurance Exchange Public Use Files To see the 2019 Health Insurance Exchange Public Use Files, visit: https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html

2019 Rate Review Public Use File To see the 2019 Rate Review Public Use File, visit: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2019-URR-PUF.zip

2019 Issuer Participation County Map To see the 2019 Issuer Participation County Map, visit: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Final-2019-County-Coverage-Map.pdf

###

2019 Assister Readiness Webinar Series

Modules of the *2019 Assister Readiness Webinar Series* are now posted! 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 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.

The first week's modules covered *Assister Roles and Responsibilities*.

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*; and

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!**

We are happy to bring you this supplemental training and hope you will all join us for this NEW and more interactive way to get ready for Open Enrollment!

###

Marketplace Call Center IDs for Assisters

Similar to the previous open enrollments, there is a designated call center line for Assisters. We strongly encourage assisters to use the assister line when working with consumers not only to receive more efficient service, but also to enable the Call

Center to better monitor and meet assisters' needs. Please note there are two different Assister lines, one for Navigators and one for CACs (state-funded assisters should use the CAC line):

- Assister Line for Navigators: 1-855-868-4678
- Assister Line for CACs: 1-855-879-2683

The line has several features designed to help better streamline the call process. When calling the Assister line, please be ready to enter your access code.

- For **Certified Designated Organizations (CACs),** your access code will be your *organization's main phone number listed on your application that was approved during the recent CDO refresh process.*
- For **Navigators,** your access code will *your organization's primary point of contact telephone number*.
- For state funded assisters in SBM-FPs, use the same code your organization was assigned in previous years.

You will be prompted to select the reason for the call:

- Request assistance with a HealthCare.gov account Password Reset
- Request an SEP not granted through the Marketplace Application
- Request Enrollment Assistance

Please note, utilizing the Assister line will only allow expedited service if you need help with password resets or accessing certain call center-initiated SEPs. This enhancement is designed to help minimize the time you have to spend on the phone trying to resolve certain consumer issues. For all other issues, the wait time will be the same as the regular call center line.

Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs and state-funded assisters) for more information on how to utilize the Assister Line. If Navigators have any difficulty accessing the Assister line, please reach out to your project officer. If CACs have any difficulty, please email the CACquestions@cms.hhs.gov.

###

Data on 2019 Individual Health Insurance Market Conditions

The Centers for Medicare and Medicaid services released data showing average premiums rates will drop in 2019 for individual health insurance plans sold on the HealthCare.gov platform.

Specifically, the average premium for the Second Lowest Cost Silver Plan (SLCSP) is expected to drop by 1.5 percent. In addition, more health insurers are entering the market in 2019, providing more plan choices for consumers. These developments suggest health insurance markets across much of the country are stabilizing after a number of difficult years.

Individual health insurance markets across the country have experienced substantial disruption in the years following the implementation of the Patient Protection and Affordable Care Act (PPACA). Average premiums more than doubled between 2013 and 2017 and increased another 27 percent in 2018. In addition, many issuers dropped out of the market in recent years, leaving more than half of U.S. counties with only one issuer in plan year 2018. Rising premiums and fewer choices resulted in a large portion of unsubsidized people dropping out of the market.

Between 2016 and 2017, unsubsidized enrollment declined by 20 percent nationally, with six states losing over 40 percent of their unsubsidized enrollment.

CMS took immediate administrative actions in 2017 to address market stability issues and to improve the performance of the Exchange in order to mitigate the deterioration of the individual health insurance market. These actions focused on

improving the individual market risk pool by encouraging people to maintain continuous coverage and attracting younger and healthier people to join the market.

After implementing these administrative actions, market conditions moving into plan year 2019 substantially improved. Data shows 2019 premiums are stabilizing for plans sold on the HealthCare.gov platform.

- Average 2019 premium rates for a benchmark plan represent the first decline in rates since the Federally-facilitated Exchange began in 2014.
    - The average second lowest cost silver plan (SLCSP) premium decreased by 1.5% in 2019. By comparison, the average SLCSP increased by 37% from 2017 to 2018.
- Actual premium increases on average may be even lower, as consumers "buy-down" coverage. When faced with high premiums, consumers have the opportunity to buy-down to coverage with higher cost sharing and lower premiums.
- Stabilizing premiums will help retain healthier people in the risk pool.

Alongside stabilizing premiums, issuer participation is also growing and expanding across the country, making health insurance markets more competitive and driven to deliver better value to consumers.

- In 2019, both market participation and county coverage are recovering from the drop seen in 2018.
    - There are 23 more issuers for 2019 than were participating during open enrollment in 2018.
- 29 current issuers are expanding their service area into more counties.
- Anthem, Wellmark, Molina, and Cigna have returned to markets they left in 2016 and 2017.
- The number of single-issuer counties has decreased.
    - 39% of counties in the FFE have a single issuer compared to 56% in 2018.
    - This means that 19.8% of enrollees have access to only one issuer down from 29.5% in 2018, and the majority of enrollees (58.0%) now have access to three of more issuers.
    - Only 5 states (AK, DE, NE, MS, WY)* will have only one issuer in 2019, compared to 10 states in 2018.

###

Trump Administration announces State Relief and Empowerment Waivers

States could develop innovative solutions to help their consumers combat skyrocketing premiums and limited plan options

The Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of the Treasury (collectively, the Departments) issued new guidance so states can move their insurance markets away from the one-size-fits-all rules and regulations imposed by the Affordable Care Act (ACA) and increase choice and competition within their insurance markets. The new guidance grants states more flexibility to design alternatives to the ACA and to give Americans more options to get health coverage that better meets their needs. Under this new policy, states will be able to pursue waivers to improve their insurance markets, increase affordable coverage options for their residents, and ensure that people with pre-existing conditions are protected. These waivers are called State Relief and Empowerment Waivers to reflect this new direction and opportunity.

"President Trump has already opened up more affordable, flexible options for Americans in the individual health insurance market, while also bringing new stability to the Exchange," said HHS Secretary Azar. "Now, states will have a clearer sense of how they can take the lead on making available more insurance options, within the bounds of the Affordable Care Act, that are fiscally sustainable, private sector-driven, and consumer-friendly."

"The Trump Administration inherited a health insurance market with skyrocketing premiums and dwindling choices," said CMS Administrator Seema Verma. "Under the President's leadership, the Administration recently announced average premiums will decline on the Federal Exchange for the first time and more insurers will return to offer increased choices. But our work isn't done. Premiums are still much too high and choice is still too limited. This is a new day – this is a new approach to empower states to provide relief. States know much better than the federal government how their markets work. With today's announcement, we are making sure that they have the ability to adopt innovative strategies to reduce costs for Americans, while providing higher quality options."

With this guidance, states will be able to develop innovative approaches that break away from the otherwise inflexible federal approach and increase consumer control and expand choice and competition in their markets. In addition to this guidance, CMS is also preparing to release waiver concepts to help spur conversations and ideas with states, and illustrate how states might take advantage of this new opportunity to move beyond the ACA.

Federal law, under Section 1332 of the ACA, authorizes states to waive certain provisions of the law so long as the new state waiver plan meets specific criteria, or "guardrails," that help guarantee people retain access to coverage that is at least as comprehensive and affordable as without the waiver, covers as many individuals, and is deficit neutral to the federal government.

However, guidance issued under the previous Administration in 2015 substantially and unnecessarily limited the types of state waiver proposals that the federal government would approve. To date, these limitations have effectively restricted state waivers to just one type, a reinsurance waiver. While this Administration has worked closely with a number of states to put single-purpose reinsurance waivers in place and these have resulted in significantly reduced premiums in those states, the statutory waiver authority set out in the ACA permits states to accomplish far more to improve choice and competition for their residents.

Today's guidance marks a new direction that delivers the flexibility the law always intended for states. To begin, the guidance outlines five principles for states to follow as they work to develop innovative new approaches. Moving forward, state waivers should aim to: provide increased access to affordable private market coverage; encourage sustainable spending growth; foster state innovation; support and empower those in need; and promote consumer-driven healthcare.

The new flexibilities available to states include the following:

- Allows states to provide consumers with plan options that best meet their needs, while, at the same time, ensuring people, including those with pre-existing conditions, retain access to the same level of coverage available today without the waiver;
- Continues to require that a comparable number of people have coverage, but expands the definition of coverage to include more types of coverage, such as short-term plans;
- Provides greater flexibility for states to consider improvements in comprehensiveness and affordability for state residents as a whole versus the prior focus on specific populations;
- Supports increased variation and flexibility for states that may want to leverage components of the Federal Exchange platform to implement new models; and
- Provides flexibility for states to meet the state legislative authority requirement. The guidance clarifies that in certain circumstances, existing state legislation that provides statutory authority to enforce ACA provisions and the state plan, combined with a duly-enacted state regulation or executive order, may satisfy the requirement that the state enact a law.

This announcement builds on recent actions taken by CMS to provide relief to American families struggling with the impacts of the ACA and rising cost of insurance. Recently finalized rules by the Departments of Health and Human Services (HHS), Labor, and the Treasury, in response to the President's October 2017 Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," expanded consumer options to use Association Health Plans and short-term plans. In April, CMS issued the HHS Notice of Benefit and Payment Parameters for 2019, which will improve program integrity, increase state flexibility, and reduce regulatory burdens of the health insurance markets for millions of Americans.

The Departments are committed to empowering states to innovate in ways that will best protect people with pre-existing conditions, strengthen their health insurance markets, expand affordable choices of coverage, target public resources to those most in need, and meet the unique circumstances of each state. We welcome comments on all aspects of the guidance.

A fact sheet on today's guidance can be found here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SRE-Waiver-Fact-Sheet.pdf

The guidance on State Relief and Empowerment Waivers can be found here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf

and on 10/24/2018 available online at https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers

###

2019 CMS QRDA III Implementation Guide, Schematron, and Sample Files Are Now Available

The Centers for Medicare & Medicaid Services (CMS) has published the 2019 CMS Quality Reporting Document Architecture (QRDA) Category III Implementation Guide (IG), Schematron, and Sample files. The 2019 CMS QRDA III IG will help eligible clinicians and eligible professionals report electronic clinical quality measures (eCQMs), improvement activities, and/or promoting interoperability measures for the calendar year 2019 performance period.

The IG provides technical instructions for QRDA III reporting for the following programs:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- Comprehensive Primary Care Plus (CPC+)
- Promoting Interoperability (PI)

The 2019 CMS QRDA III IG contains the following high-level changes from the 2018 QRDA III IG Version 2 (last updated July 27, 2018):

- Increased alignment with its base standard, the HL7 QRDA III STU R2.1 IG
- Now shows the template changes from the base HL7 QRDA III STU R2.1 IG only
- Updated eCQM Universally Unique Identifiers (UUIDs) for the 2019 performance period eCQMs that were released on May 4, 2018. Please note, measures will not be available for 2019 reporting unless they are proposed and finalized through notice-and-comment rulemaking for the applicable program year.

The following changes are present in both the 2018 CMS QRDA III IG V2 (last updated July 27, 2018) and the 2019 CMS QRDA III IG:

- The templates have been updated to report the performance period at the individual measure/activity level. The performance period under MIPS can be reported at the individual measure level for the MIPS quality measures and at the individual activity level for the MIPS improvement activities (IA), as defined by CMS, or the performance category level for Quality and IA performance categories. Performance period reporting for Promoting Interoperability (formerly Advancing Care Information) and CPC+ remains at the category level.
- The addition of a new CMS program name code "MIPS_VIRTUALGROUP" to support MIPS virtual group reporting.

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.

###

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Data on Nursing Home Compare

This fact sheet contains information about the inaugural release of the SNF QRP data on the Nursing Home Compare website that occurred on October 24, 2018.

Why is this information being released?

In accordance with Section 1899B(g)(1) of the Social Security Act, which requires CMS to provide for the public reporting of SNF provider performance on the quality measures, CMS is announcing the inaugural release of the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) quality data on Nursing Home (NH) Compare. The law requires certain post-acute care (PAC) providers, including SNFs, to report provider performance data on quality. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act also requires CMS to publicly report quality measure data submitted by SNFs on certain quality measures specified in the Act.

Why is the SNF QRP data being posted on Nursing Home Compare?

Nursing Home Compare allows you to find and compare SNFs that are certified by Medicare and nursing facilities that are certified by Medicaid collectively referred to as nursing homes. This website contains quality of resident care and staffing information for more than 15,000 nursing homes around the country, and will now include SNF QRP quality data that can be used to help compare SNF providers by their performance on important indicators of quality, such as the percentage of a SNF's residents that develop pressure ulcers, or how many residents fall and are injured as a result of the fall.

What can I learn from reviewing this data?

These data can demonstrate how a SNF's performance on SNF QRP quality measures compares to that of other SNFs, as well as to the national average. These data can showcase a SNF's ongoing commitment to quality, improving engagement and confidence among staff, residents, caregivers, families, and stakeholders.

What is the source of this publicly reported data? The SNF QRP data used for calculating measures include claims data for some measures and for others the data are collected and submitted to CMS via the Minimum Data Set (MDS), which is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. SNFs must complete a MDS admission record and discharge record on each resident that enters that SNF for care. The SNF QRP measures are calculated based on the admission and discharge data submitted for each SNF resident.

What are the SNF QRP quality measures that have been added to Nursing Home Compare?

CMS has added the following five SNF QRP measures to Nursing Home Compare:

Assessment-based measures:

1. Percent of Residents or Patients in a SNF that develop new or worsened pressure ulcers (National Quality Forum #0678)
2. Percentage of residents or patients whose activities of daily living and thinking skills were assessed and related goals were included in their treatment plan (NQF #2631)
3. Percentage of SNF patients who experience one or more falls with major injury during their SNF stay (NQF #0674)

Claims-based measures:

1. Medicare Spending Per Beneficiary (MSPB) for patients in SNFs
2. Rate of successful return to home or community from an SNF

CMS has decided not to publish a 6th quality measure, Potentially Preventable 30-Day Post-Discharge Readmissions, at this time. Additional time would allow for more testing to determine if there are modifications that may be needed both to the measure and to the method for displaying the measure. This additional testing will ensure that the future publicly reported measure is thoroughly evaluated so that Compare users can depend upon an accurate picture of provider quality. While we conduct this additional testing, CMS will not post reportable data for this measure, including each SNF's performance, as well as the national rate.

Summary of Findings – The following table lists the new SNF QRP measures that are included on Nursing Home Compare and displays the national average rate of performance on the measures.

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Measure Name and Description	National Rate of Quality Measure Performance
Minimum Data Set (MDS)-based Measures	
Percent of Residents or Patients in a SNF that develop new or worsened pressure ulcers (National Quality Forum #0678)	1.7%

· Percent of patients that developed new or worsening pressure ulcers during their stay in an SNF	
Percentage of residents or patients whose activities of daily living and thinking skills were assessed and related goals were included in their treatment plan (NQF #2631) · Percentage of patients whose activities of daily living and thinking skills were assessed and related goals were included in their treatment plan	95.8%
Percentage of SNF patients who experience one or more falls with major injury during their SNF stay (NQF #0674) · Percentage of patients that experienced a fall that resulted in a major injury during their stay in a SNF	0.9%
SNF Claims-based Measures	
Medicare Spending Per Beneficiary (MSPB) for patients in SNFs · Shows whether Medicare spends more, less, or about the same on an episode of care for a Medicare patient treated in a specific SNF compared to how much Medicare spends on an episode of care across all SNFs nationally	1.01
Rate of successful return to home or community from an SNF The rate at which patients returned to home or community from the SNF and remained alive without any unplanned hospitalizations in the 31 days following discharge from the SNF.LTCH. The rate at which patients returned to home or community from the SNF and remained alive without any unplanned hospitalizations in the 31 days following discharge from the SNF	48.57%

Resources Available to Skilled Nursing Facilities

- Visit the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) webpage for more information on Hospice Compare.
- Visit the SNF QRP Measures and Technical Information webpage for more information on submitting data to CMS.

Help Desks

- **For questions related to the SNF Quality Reporting Program including:**
  - SNF Quality Reporting Program requirements
  - General quality reporting requirements and reporting deadlines
  - SNF Quality Reporting Program quality measures
  - MDS 3.0 coding instructions for Part A PPS Discharge assessment and Section GG
  - Data reported in the SNF QRP CASPER Review and Correct reports
  - Data reported in the SNF QRP CASPER Quality Measure reports
    - Email: SNFQualityQuestions@cms.hhs.gov

- **For questions related to Public Reporting of quality data including:**
  - Questions related to SNF Provider Preview reports
  - Requests for the CMS review of the data contained within the Provider Preview Report that a SNF may believe to be erroneous

    - Questions related to SNF Public Reporting, including SNF QRP Public Reporting on Nursing Home Compare and/or SNF QRP data on data.medicare.gov
- Email: SNFQRPPRQuestions@cms.hhs.gov

Subscribe to the PAC QRP listserv for the latest SNF quality reporting and IMPACT Act program information including but not limited to training, stakeholder engagement opportunities, and general updates about reporting requirements, quality measures, and reporting deadlines.

Additional Compare Sites

- Dialysis Compare
- Home Health Compare
- Hospital Compare
- Inpatient Rehabilitation Facility (IRF) Compare
- Long-Term Care Hospital (LTCH) Compare
- Medicare Plan Finder
- Hospice Compare
- Physician Compare

###

Updated Ranking File – Skilled Nursing Facilities (SNFs)

The Centers for Medicare & Medicaid Services (CMS) thanks all skilled nursing facilities (SNFs) that participated in Phase Two of the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program's Review and Corrections process. As a result, CMS is providing updated rankings for all SNFs included in the Fiscal Year (FY) 2019 program year. A list of each SNF's incentive payment multiplier and updated ranking can be found on the SNF VBP website. The incentive payment multiplier applicable to each SNF is unchanged from the multiplier that CMS previously included in the SNF's FY 2019 Annual Performance Score Report. That multiplier will be used to adjust the Federal per diem rate otherwise applicable to the SNF for services furnished from October 1, 2018 through September 30, 2019. A more detailed file containing facility level performance will be made publicly available later this year on *Nursing Home Compare*.

The Review and Corrections process provides SNFs with the opportunity to review the information that will be made public for the applicable SNF VBP program year and to submit correction requests to CMS. As a reminder, Phase One Review and Correction requests are due no later than March 31, 2019 for Calendar Year 2017 measure data. To submit a complete request, SNFs must submit the following information to the SNFVBPinquiries@cms.hhs.gov mailbox:

- The SNF's CMS Certification Number (CCN)
- The SNF's Name
- The correction requested and the reason for requesting the correction. SNFs must also submit evidence, if available, supporting the request.

Please do not include any protected health information or other patient-level data in correction requests submitted to the SNF VBP mailbox.

For more information on how to review the FY 2019 Annual Performance Score Report, view this tutorial. Click this link to access the FY 2019 Annual Performance Score Report. For questions about accessing CASPER, please contact the QIES Technical Support Office (QTSO) Help Desk: help@qtso.com.

For more information about the SNF VBP Program, please review the Frequently Asked Questions document and refer to the FY 2019 SNF PPS final rule.

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

###

SNF Provider Preview Reports- Now Available

Skilled Nursing Facility Provider Preview Reports have been updated and are now available. Providers have until November 30, 2018 to review their performance data on quality measures based on Quarter 2 -2017 to Quarter 1 - 2018 data, prior to the January 2019 Nursing Home Compare site refresh, during which this data will be publicly displayed. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate.

For More Information we invite you to visit: CMS SNF Quality Public Reporting webpage, which also includes directions for accessing your preview report.

###

Prepare For 2018 MIPS Data Submission by Obtaining Your Enterprise Identification Management (EIDM) Credentials Now

The 2018 performance year for the Merit-based Incentive Payment System (MIPS) ends on December 31, 2018. To access the Quality Payment Program Portal and submit your 2018 performance data, you'll need your EIDM User ID and Password.

Creating an EIDM Account

CMS established the EIDM system to provide clinicians and practices with a single User ID that can be used to access one or more CMS Applications.

How to Obtain an EIDM Account

If you do not have an EIDM account, navigate to the CMS Enterprise Portal and select 'New User Registration' to create one. The following information is required for registration:

- Application Name
- Application Role
- Organization Legal Business Name, Address, and Phone Number
- Taxpayer Identification Number (TIN) and corresponding individual Provider Transaction Access Number (PTAN)

Your organization or CMS can help you identify the information needed for your application.

Once you complete your EIDM account registration, you will receive an e-mail acknowledging your successful account creation with your EIDM User ID. Use your unique EIDM User ID and Password to login to the Quality Payment Program Portal.

CMS encourages you to create an EIDM account or verify your EIDM credentials now to prepare for your 2018 MIPS data submission.

For More Information:

- Review the EIDM User Guide
- Contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292/TTY: 1-877-715-6222.
- Visit the Quality Payment Program Website

###

The Quality Payment Program Resource Library is Back on QPP.CMS.GOV

Visit the Quality Payment Program Website to Find Available Resources

The Centers for Medicare & Medicaid Services (CMS) has moved Quality Payment Program (QPP) resources from CMS.gov to the newly redesigned Quality Payment Program Resource Library on qpp.cms.gov. Following feedback from clinicians and others in the health care community, we wanted to make Quality Payment Program information and resources available in one place. We've also made it easier for you to find the resources you're looking for by including a search function that allows you to search for resources by year, reporting track, performance category, and by document type (e.g., fact sheet, user guide, measure specifications).

Additional resources including materials from educational webinars will be added to the new Quality Payment Program Resource Library soon. Stay tuned for more information!

For More Information

- Go to the Quality Payment Program Resource Library to review Quality Payment Program resources.
- Visit the Quality Payment Program website to check your participation status, explore measures, and to review guidance on MIPS, APMs, what to report, and more.

###

Available Now: Multi-Payer Other Payer Advanced APMs List

View New Other Payer Advanced APM Resources

Under the Quality Payment Program's All-Payer Combination Option, State Medicaid Agencies, Medicare Advantage and other Medicare Health Plans, as well as commercial and private payers participating in CMS-sponsored Multi-Payer payment arrangements (CMS Multi-Payer Models), may submit information to CMS about their payment arrangements with eligible clinicians. CMS will determine whether each submitted payment arrangement constitutes an Other Payer Advanced Alternative Payment Model (APM) for a given Performance Year. If a payer chooses not to (or is not eligible to) submit its arrangements to CMS, eligible clinicians or APM Entities participating in the payment arrangement may do so.

We are publishing a list of payment arrangements with CMS Multi-Payer Models that CMS has determined to be Other Payer Advanced APMs for the Calendar Year (CY) 2019 QP Performance Period, based on submissions from payers made earlier this year through the Payer Initiated Process, and based on the Other Payer Advanced APM criteria in effect. The list is in the document on the QPP Resource Library under the title "**2019 QPP Multi-Payer Other Payer Advanced APMs**."

For More Information

- Visit the Quality Payment Program Website
- Contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292/TTY: 1-877-715-6222.

###

Physician Fee Schedule and QPP: Changes to Advance Innovation, Restore Focus on Patients

On November 1, CMS finalized bold proposals that address provider burnout and provide clinicians immediate relief from excessive paperwork tied to outdated billing practices. The final 2019 Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) rule also modernizes Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services, no matter where they live. It makes changes to ease health information exchange through improved interoperability and updates QPP measures to focus on those that are most meaningful to positive outcomes. The rule also updates some policies under Medicare's Accountable Care Organization program that streamline quality measures to reduce burden and encourage better health outcomes. This rule is projected to save clinicians $87 million in reduced administrative costs in 2019 and $843 million over the next decade.

"The historic reforms CMS finalized today move us closer to a health care system that delivers better care for Americans at lower cost," said HHS Secretary Alex Azar. "Among other advances, improving how CMS pays for drugs and for physician visits will help deliver on two HHS priorities: bringing down the cost of prescription drugs and creating a value-based health care system that empowers patients and providers."

"Today's rule finalizes dramatic improvements for clinicians and patients and reflects extensive input from the medical community," said CMS Administrator Seema Verma. "Addressing clinician burnout is critical to keeping doctors in the workforce to meet the growing needs of America's seniors. Today's rule offers immediate relief from onerous requirements that contribute to burnout in the medical profession and detract from patient care. It also delays even more significant changes to give clinicians the time they need for implementation and provides time for us to continue to work with the medical community on this effort."

Coding requirements for physician services known as "Evaluation and Management" (E/M) visits have not been updated in 20 years. This final rule addresses longstanding issues and also responds to concerns raised by commenters on the proposed rule. CMS is finalizing several burden-reduction proposals immediately (effective January 1, 2019), where commenters provided overwhelming support. In response to concerns raised on the proposal, the final rule includes revisions that preserve access to care for complex patients, equalize certain payments for primary and specialty care, and allow for continued stakeholder engagement by delaying implementation of E/M coding reforms until 2021.

For the first time this rule will also provide access to "virtual" care. Medicare will pay providers for new communication technology-based services, such as brief check-ins between patients and practitioners and pay separately for evaluation of remote pre-recorded images and/or video. CMS is also expanding the list of Medicare-covered telehealth services. This will give seniors more choice and improved access to care.

In addition, the rule continues our work to deliver on President Trump's commitment to lowering prescription drug costs. Effective January 1, 2019, payment amounts for new drugs under Part B will be reduced, decreasing the amount seniors have to pay out-of-pocket, especially for drugs with high launch prices.

CMS is also finalizing an overhaul of Electronic Health Record (EHR) requirements in order to focus on promoting interoperability. The rule finalized changes to help make EHR tools that actually support efficient care instead of hindering care. Final policies for Year 3 of the QPP, part of the agency's implementation of MACRA, will advance the Meaningful Measures initiative while reducing clinician burden, ensuring a focus on outcomes, and promoting interoperability. CMS also introduced an opt-in policy so that certain clinicians who see a low volume of Medicare patients can still participate in the Merit-based Incentive Payment System program if they choose to do so. In addition, CMS is providing the option for clinicians who are based at a health care facility to use facility-based scoring to reduce the burden of having to report separately from their facility.

For More Information:

- Final Rule
- PFS Fact Sheet
- QPP Fact Sheet
- E/M Payment Amounts Chart

See the full text of this excerpted CMS Press Release (November 1).

###

DME and ESRD Programs: Policies to Modernize and Drive Innovation

On November 1, CMS finalized innovative changes to the Medicare payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) programs. The policies aim to increase access to items and services for patients, drive competition and increase affordability.

"The rule finalized today makes innovative changes to the Medicare payment rules for the durable medical equipment and end-stage renal disease programs. It also helps to ensure continued access to durable medical equipment and makes significant improvements to our competitive bidding system." said CMS Administrator Seema Verma. "Based on many comments we received on our DME proposal from suppliers, manufacturers and their associations -- all of whom supported our proposals -- we are implementing market-oriented reforms to Medicare's DMEPOS Competitive Bidding Program that also reduce burden on suppliers by simplifying the bidding process."

Improved Access to Durable Medical Equipment (DME)

The rule finalizes market-oriented reforms to the Medicare's DMEPOS Competitive Bidding Program (CBP). The final rule will increase beneficiary access to items and services, leverage opportunities to increase the program's effectiveness and better ensure the long-term sustainability of the DMEPOS CBP by streamlining the program and strengthening the bidding rules. Changes to the DMEPOS CBP that we finalized also will reduce burden on suppliers by simplifying the bidding process. This rule establishes lead item bidding, which means suppliers will only need to submit one bid per product category. In addition, the single payment amounts for items in each product category under the DMEPOS CBP would apply to the lead item in the product category. These changes streamline the program, enhance quality and access to innovative products, and help ensure the long term sustainability of the program and the savings it generates. Also, the rule finalizes increases in DMEPOS fee schedule rates, using a blend of adjusted and unadjusted fee amounts, in order to protect access to needed durable medical equipment in rural areas that are not subject to the DMEPOS CBP.

The process for recompeting contracts with suppliers currently in effect under the DMEPOS CBP has not yet been initiated and the current contracts for the DMEPOS CBP will expire on December 31, 2018. As a result, starting January 1, 2019, and until new contracts are awarded under the DMEPOS CBP, there will be a temporary gap period in the entire DMEPOS CBP and National Mail Order CBP that CMS expects will last two years until December 31, 2020. During that time, Medicare beneficiaries will continue to receive DMEPOS items from any Medicare-enrolled DMEPOS supplier and in most cases, they won't need to switch suppliers.

As required by the 21st Century Cures Act, this rule also finalizes Medicare fee schedule payments for DME furnished on or after January 1, 2019 in areas of the country where competitive bidding is not in effect. For more information, see the Temporary Gap Period fact sheet.

End-Stage Renal Disease Prospective Payment System

CMS is also taking steps to support innovation in Medicare's ESRD Prospective Payment System by expanding the Transitional Drug Add-on Payment Adjustment (TDAPA) for new ESRD drugs and biologicals, effective January 1, 2020. As the largest payer for kidney care, expanding TDAPA to all new renal dialysis drugs and biological products will help incentivize the development and use of transformative and innovative therapies.

Finally, this final rule takes significant steps forward by strengthening quality incentives, improving patient outcomes and reducing administrative burden. These changes advance the Patients Over Paperwork initiative and will allow doctors to spend less time on paperwork and more time with their patients. Based on stakeholder feedback, CMS reduced ESRD facility-related documentation burdens for the comorbidity payment adjustment so that the documentation requirements are more consistent with other payment systems. CMS also reduced the reporting burden for the ESRD Quality Incentive Program by finalizing a more limited measure set that better aligns with the CMS Meaningful Measures Initiative.

For More Information:

- Final Rule
- Fact Sheet

See the full text of this excerpted CMS Press Release (issued November 1).

###

CMS Releases Final Rule for the 2019 Quality Payment Program

The Centers for Medicare and Medicaid Services (CMS) issued its policies for Year 3 (2019) of the Quality Payment Program via the Medicare Physician Fee Schedule (PFS) Final Rule. The provisions in the rule build on the foundation established in the first two years of the program, and are reflective of the feedback we received from many stakeholders.

Year 3 Final Rule Policy Highlights

In Year 3 of the Quality Payment Program, we are continuing to use the framework established by the Patients Over Paperwork initiative, implement meaningful measures, promote interoperability, support small and rural practices, reduce clinician burden, and improve patient outcomes.

Key policies for Year 3 include:

- Expanding the definition of a Merit-based Incentive Payment System (MIPS)-eligible clinician to include new clinician types, including physical therapists, occupational therapists, speech-language pathologists, audiologists, clinical psychologists, and registered dietitians or nutrition professionals.
- Adding a third element (Number of Covered Professional Services) to the low-volume threshold determination and providing an opt-in policy that offers eligible clinicians who meet or exceed one or two, but not all, elements of the low-volume threshold the ability to participate in MIPS.
- Applying facility-based scoring automatically for eligible facility-based clinicians without data submission requirements for individual clinicians and using group data submissions in the MIPS Promoting Interoperability or improvement activities categories to identify groups for facility-based scoring determinations.
- 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 recent changes to the Promoting Interoperability Program requirements for hospitals.
- Moving clinicians to a smaller set of objectives and measures with scoring based on performance for the Promoting Interoperability performance category.
- Allowing small practices to submit quality data for covered professional services through the Medicare Part B claims submission type for the Quality performance category.
- Streamlining the definition of a MIPS comparable measure in both the Advanced Alternative Payment Models (APMs) criteria and Other Payer Advanced APM criteria to reduce confusion and burden amongst payers and eligible clinicians submitting payment arrangement information to CMS.
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.
- Updating the Advanced APM and Other Payer Advanced APM Certified EHR Technology (CEHRT) threshold so that these must require that at least 75% of eligible clinicians use CEHRT, and for Other Payer Advanced APMs, as of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using CEHRT must also be 75%.
- Extending the 8% revenue-based nominal amount standard for Advanced APMs and Other Payer Advanced APMs through performance year 2024.
- Finalizing proposals to implement the Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration in 2018 under the authority in section 402(b) of the Social Security Amendments of 1967 (as amended).

For More Information

To learn more about the PFS Final Rule and the Year 3 Quality Payment Program policies, review the following resources:

- Press release – includes more details about today's announcement
- Executive Summary – provides a high-level summary of the Quality Payment Program Year 3 final rule policies
- Fact Sheet – offers an overview of the policies for Year 3 (2019) and compares these policies to the current Year 2 (2018) requirements

CMS also encourages you to register for the **Quality Payment Program Year 3 Final Rule Webinar** on November 15 at 12:00 PM ET.

Help and Support

CMS will continue to provide no-cost technical assistance to help individual clinicians, groups, and virtual groups participate in the Quality Payment Program. To learn more about our technical assistance options, visit the Quality Payment Program website.

You can also contact the Quality Payment Program via:

- Phone: 1-866-288-8292 (TTY: 1-877-715-6222)
- Email: QPP@cms.hhs.gov

For more information about the Quality Payment Program, please visit: QPP.CMS.GOV

###

CMS Finalizes Changes to Advance Innovation, Restore Focus on Patients

On November 1, the Centers for Medicare & Medicaid Services (CMS) finalized bold proposals that address provider burnout and provide clinicians immediate relief from excessive paperwork tied to outdated billing practices. The final 2019 Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) modernizes Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services, no matter where they live. It makes changes to ease health information exchange through improved interoperability and updates QPP measures to focus on those that are most meaningful to positive outcomes.

In addition, the rule also updates some policies under Medicare's accountable care organization (ACO) program that streamline quality measures to reduce burden and encourage better health outcomes, although broader reforms to Medicare's ACO program were proposed in a separate rule. This rule is projected to save clinicians $87 million in reduced administrative costs in 2019 and $843 million over the next decade.

For More Information

To learn more about the PFS final rule, review the following resources:

- Press release – includes more details about today's announcement
- Fact Sheet

###

CMS Takes Action to Modernize Medicare Home Health

On October 31, CMS finalized significant changes to the Home Health Prospective Payment System (PPS) to strengthen and modernize Medicare. Specifically, CMS made changes to improve access to solutions via remote patient monitoring technology, updated payments for home health care with a new case-mix system, begin the new home infusion therapy benefit, and reduce burden.

"This home health final rule focuses on patient needs and not on the volume of care," said CMS Administrator Seema Verma. "This rule also innovates and modernizes home health care by allowing remote patient monitoring. We are also proud to offer new home infusion therapy services. Using new technology and reducing unnecessary reporting measures for certifying physicians will result in an annual cost savings and provide Home Health Agencies (HHAs) and doctors what they need to give patients a personalized treatment plan that will result in better health outcomes."

Beginning with CY 2020, CMS is implementing changes required by law, including a new case-mix system called the Patient-Driven Groupings Model (PDGM) that puts the focus on patient needs rather than volume of care. The PDGM relies more heavily on patient characteristics to more accurately pay for home health services.

CMS is promoting innovation and modernization of home health care by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data are shared among patients, their caregivers and their providers. The use of such technology can allow for greater patient independence and empowerment. Supporting patients in sharing their data will advance the MyHealthEData initiative.

This final rule implements the temporary transitional payments for home infusion therapy services for CYs 2019 and 2020, as required by the Bipartisan Budget Act of 2018, until the new permanent home infusion therapy services benefit begins on January 1, 2021. In addition, the final rule establishes the health and safety standards for qualified home infusion therapy suppliers of the new permanent home infusion therapy service benefit. The final rule also establishes the approval and oversight process for accrediting organizations of these suppliers as required by the 21st Century Cures Act. We are finalizing our proposal and also seeking further comments on our interpretation of "infusion drug administration calendar day" and on its potential effects on access to care.

CMS is eliminating the requirement that the certifying physician estimate how much longer home health services are needed when recertifying the need for continued home health care. This results in an estimated reduction in burden for physicians of $14.2 million, annually, and would allow physicians to spend more time with patients rather than on unnecessary paperwork.

The final rule helps advance the Comprehensive Meaningful Measures Initiative. CMS is removing seven Home Health Quality Reporting Program measures. Changes in data collection under the new case-mix system, coupled with the changes from these seven measure removals will reduce burden for HHAs by approximately $60 million annually, beginning in CY 2020.

For More Information:

- Final Rule
- Fact Sheet
- Home Health PPS website
- HHA Center website
- Home Health Quality Reporting Requirements webpage

###

Medicare Open Enrollment is Here until December 7th for Medicare Beneficiaries

Medicare is health insurance for people who qualify based on being 65 years of age or older, and others who may be on Medicare because of a disability. Between October 15th and December 7th is the Time to be Open to Medicare Coverage Options for 2019 – the one time of year ALL beneficiaries can make changes to the way they receive their Medicare.

Below is a link of media materials for your use in educating some of our most vulnerable populations, about the importance of Medicare Open Enrollment.
Here is the multimedia news release: https://www.multivu.com/players/English/8410451-cms-medicare-open-enrollment/. *All materials available on this site have been paid for and developed by the U.S. Department of Health & Human Services. They are provided for free use and will expire on December 31st, 2018.*

Background for beneficiaries:

- Medicare's annual Open Enrollment period starts on October 15th and ends on December 7th. The Open Enrollment period is the time for you to review your current coverage and decide if there are better coverage options for you based on changes to the current plans, your budget and your health needs.
- During Medicare Open Enrollment, you can decide to stay with your Original Medicare coverage or join a Medicare Advantage Plan. The Open Enrollment period gives everyone with Medicare the opportunity to make changes to their Medicare health plans or prescription drug plans for coverage beginning January 1, 2019.
- Think about what matters most to you and be open to your options, like Medicare Advantage plans from private insurers.
- Most often when Medicare beneficiaries review and compare plans for next year, they find more cost-effective plans to enroll in.
- If you are satisfied with your current coverage, and costs you do not have to do anything.
- **There is free help available to compare options by calling 1-800-633-4227 (1-800-Medcare) and asking for the State Health Insurance Assistance Program (SHIP) in your state.**

We would appreciate your use of the materials in the link provided, for your Medicare viewers and their families.
If you plan on using any of the materials in the link above, please let Julie Brookhart (Julie.Brookhart@cms.hhs.gov) know.

###

CMS Announces 2019 Medicare Parts A & B Premiums and Deductibles

The Centers for Medicare & Medicaid Services (CMS) announced the 2019 premiums, deductibles, and coinsurance amounts for Medicare Parts A and B.

"CMS is committed to empowering beneficiaries with the information they need to make informed decisions about their healthcare," said CMS Administrator Seema Verma. "In addition to the information we recently released for Medicare Advantage, the program through which private plans provide Medicare benefits, today we are releasing information for fee-for-service Medicare, so enrollees understand their options for receiving Medicare benefits."

As announced earlier this month, CMS 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. Ahead of Medicare Open Enrollment – which begins on October 15, 2018 and ends December 7, 2018 – CMS is making improvements the Medicare.gov website to help beneficiaries compare options and decide if Original Medicare or Medicare Advantage is right for them. Among the tools released as part of the eMedicare Initiative is a stand-alone, mobile optimized out of pocket cost calculator that will provide information on both overall costs and prescription drug costs.

Medicare Part B Premiums/Deductibles

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A.

The standard monthly premium for Medicare Part B enrollees will be $135.50 for 2019, a slight increase from $134 in 2018. An estimated 2 million Medicare beneficiaries (about 3.5 percent) will pay less than the full Part B standard monthly premium amount in 2019 due to the statutory hold harmless provision, which limits certain beneficiaries' increase in their Part B premium to be no greater than the increase in their Social Security benefits.

CMS also announced that the annual deductible for Medicare Part B beneficiaries is $185 in 2019, an increase from $183 in 2018.

Medicare Part A Premiums/Deductibles

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A inpatient deductible that beneficiaries will pay when admitted to the hospital is $1,364 in 2019, an increase of $24 from $1,340 in 2018.

Medicare Advantage Premiums

Medicare beneficiaries can choose to enroll in fee-for-service Medicare (Parts A and B) or can select a private Medicare Advantage plan to receive their Medicare benefits. Premiums and deductibles for Medicare Advantage and Medicare Prescription Drug plans are already finalized and are unaffected by this announcement.

Last month, CMS released the benefit, premium, and cost sharing information for Medicare Advantage plans in 2019. On average, Medicare Advantage premiums will decline while plan choices and new benefits increase. On average, Medicare Advantage premiums in 2019 are estimated to decrease by six percent to $28, from an average of $29.81 in 2018.

For a fact sheet on the 2019 Medicare Parts A & B premiums and deductibles, please visit: https://www.cms.gov/newsroom/fact-sheets/2019-medicare-parts-b-premiums-and-deductibles.

For more information on the 2019 Medicare Parts A and B premiums and deductibles (CMS-8068-N, CMS-8069-N, CMS-8070-N), please visit https://www.federalregister.gov/public-inspection.

###

CY 2019 OPPS and ASC Rule Encourages More Choices and Lower Costs for Seniors

On November 2, CMS released a final rule that strengthens the Medicare program by providing seniors more choices and lower cost options in making the best decisions on their care. The policies adopted in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period will help lay the foundation for a patient-driven healthcare system.

"President Trump is committed to strengthening Medicare and lowering costs for patients. Today's rule advances competition by creating a level playing field for providers so they can compete for patients on the basis of quality and care," said CMS Administrator Seema Verma. "The final policies remove unnecessary and inefficient payment differences so patients can have more affordable choices and options."

To increase the sustainability of the Medicare program and improve the quality of care for patients, CMS is finalizing its proposed method to control unnecessary volume increases for certain clinical visits by utilizing site-neutral payments for these visits. This change will be phased in over two years. Clinic visits are the most common service billed under the OPPS. Currently, CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting. This policy would result in lower copayments for beneficiaries and savings for the Medicare program in an estimated amount of $380 million for 2019. For example, for a clinic visit furnished in an excepted off-campus provider-based department (PBD), average beneficiary cost sharing is currently $23. Under this final rule, that cost sharing would be reduced to $16 (based on a two year phase-in), saving beneficiaries an average of $7 each time they visit an off-campus department in CY 2019.

Additionally, CMS is giving patients more options on where to obtain care by increasing the services that can be furnished in ASCs. These changes are intended to help improve access and convenience and ensure that CMS policies are not favoring any particular provider type. For 2019, CMS is finalizing policies that will:

- Expand the number of surgical 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 generally parallels the payment amount provided to hospital outpatient departments for these devices
- Help ensure that ASCs remain competitive by addressing the differential between how ASC payment rates and hospital outpatient department payment rates are updated for inflation

As part of the agency's "Patients Over Paperwork" Initiative—a cross-cutting process that evaluates and streamlines regulations with the goal of reducing burden—CMS is finalizing proposals to remove measures from the Hospital Outpatient Quality Reporting Program and from the Ambulatory Surgery Center Quality Reporting Program. These removals are aimed at enabling providers to focus on tracking and reporting the measures that are most impactful on patient care. This action will decrease burden for providers by approximately $27 million over the next two years.

In 2018, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments that were acquired through the 340B program—a program that allows certain hospitals to buy outpatient drugs at lower cost. Due to CMS' policy change, Medicare beneficiaries are now benefitting 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 on this policy by extending the 340B payment change to additional off-campus provider-based hospital outpatient departments that are paid under the Physician Fee Schedule.

In response to recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis, to comply with the requirements of the SUPPORT for Patients and Communities Act (P.L. 115-271), and to avoid any potential unintended consequences that would encourage overprescribing of opioids, CMS is removing questions regarding pain communication from the hospital patient experience survey. Additionally, CMS is adopting a policy to encourage increased use of non-opioid drugs following a surgical procedure in the ASC setting.

The President's Commission on Combating Drug Addiction and the Opioid Crisis also recommended that CMS review its payment policies for certain drugs that function as a supply, specifically non-opioid pain management treatments. Payment for drugs that function as a supply in surgical procedures or diagnostic tests is packaged under the OPPS and ASC payment systems. However, in response to this recommendation as well as stakeholder comments and peer-reviewed evidence, for 2019, CMS is finalizing the proposal to pay separately at average sales price plus 6 percent for non-opioid pain management drugs that function as a supply when used in a covered surgical procedure performed in an ASC.

For More Information:

- Final Rule
- Fact Sheet

Read the full text of this excerpted CMS Press Release (issued November 2)

###

Putting Patients First: Improving Health Outcomes for Hispanic Americans

By Cara V. James, Director of the CMS Office of Minority Health

As part of CMS' ongoing efforts to put patients first and empower them to work with their providers so that they make health care decisions that are best for them and their families, we want to recognize the importance of understanding the challenges and recognizing the diversity within our communities. We want to take this opportunity to look at health and health outcomes of American citizens whose ancestors came from Spain, Mexico, the Caribbean, Central America, and South America. The first step to establish understanding is to have data informed strategy that allows us to increase understanding and awareness of the diversity within the Hispanic community and identify challenges they may face in accessing care that meets their needs.

Hispanic Americans are the largest ethnic or racial minority group in the United States making up nearly 18% of the total population[1]. Within that 18%, we see the range of ancestral origin, 63% Mexican, 9.5% Puerto Rican, 4% Cuban, 4% Salvadoran, and 3% Dominican Republic represent the top 5 subpopulations among Hispanic Americans[2]. The

importance of understanding this diversity becomes apparent when we see that variation in health outcomes among Hispanic Medicare beneficiaries, more than 50% of those that identify as multi-ethnic and Puerto Ricans rated their health as fair or poor while approximately 40% of those that identify as Cuban rated their health that way. Understanding the diversity also allows us to identify unique challenges and opportunities within each community.

Seizing on those challenges and opportunities, our data informed strategy also allows us to develop and disseminate solutions to help patients and providers make decisions that are right for them, while also working to improve overall health care quality. To assist organizations in developing their own data informed strategy, CMS has developed resources such as a Compendium of Resources for Standardized Demographic and Language Data Collection, to help them set up data collection efforts that will assist them in better understanding their patients, identifying disparities in quality of care, and targeting quality improvement intervention.

A data informed strategy also provides the opportunity to empower patients and improve their experience accessing and receiving care. To help patients in making decisions that are best for them, CMS has expanded the offering of From Coverage to Care resources. A Roadmap to Behavioral Health: A Guide to Using Mental Health and Substance Use Disorder Services, available in English and Spanish, focuses on behavioral health to offer important information about mental health and substance use disorder services, finding a behavioral health provider, defining behavioral health terms, receiving services, and following up on care. As we gear up for open enrollment, My Health Coverage at a Glance acts as a quick reference to track key pieces of their health coverage information.

Putting patients first is at the center of what we do at CMS. This means working together with patients and providers to identify and address the unique challenges they face and help amplify solutions that will help them meet their needs. By using data to increase understanding of our nation's diversity and applying that knowledge to the development and dissemination of solutions, we can implement sustainable actions to help Hispanic Americans improve their health and that of their families.

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[1] https://www.census.gov/library/audio/profile-america/profileodd/profile-odd-15.html

[2] http://www.pewresearch.org/fact-tank/2017/09/18/how-the-u-s-hispanic-population-is-changing/

###

CMS Takes Steps to help with Hurricane Michael Emergency Response

Agency waivers to take effect in Florida

The Centers for Medicare & Medicaid Services (CMS) announced steps taken by the agency to support Florida in response to Hurricane Michael. Yesterday, Health and Human Services Secretary Alex Azar declared a public health emergency (PHE) in Florida. With the PHE in effect, CMS has taken several actions to provide immediate relief to those impacted by the hurricane. The actions will include temporarily waiving or modifying certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements; creating special enrollment opportunities for individuals to access healthcare immediately; and taking steps to ensure dialysis patients obtain critical life-saving services.

"Reports have said that Hurricane Michael is an extremely dangerous storm and we urge those in the path to take steps to be safe," Administrator Seema Verma said. "CMS has taken the measures necessary to help support everyone that could be impacted. The waivers that will be in effect in Florida will give healthcare providers, facilities, and suppliers the flexibility to provide continued access to care throughout this storm. We will continue to monitor the hurricane and work closely with officials in Florida."

Below are key administrative actions CMS is taking in response to the PHE declared in Florida:

- **Waivers for Hospitals, Healthcare Facilities, and Clinicians:** CMS will be temporarily waiving or modifying certain Medicare, Medicaid, and CHIP requirements. CMS will be issuing a number of waivers as necessary, which will be listed on the website below, and the CMS Regional Offices will be granting other provider-specific requests for specific types of hospitals and other facilities in Florida. These waivers work to provide continued access to care for

beneficiaries. For more information on the waivers CMS will grant, visit: www.cms.gov/emergency.

- **Special Enrollment Opportunities for Individuals Impacted by the Hurricane:** CMS has made special enrollment periods available for certain individuals seeking health plans offered through the Federal Health Insurance Exchange and all Medicare beneficiaries. This gives people impacted by the hurricane the opportunity to gain access to health coverage on the Exchange or change their Medicare health and prescription drug plans immediately if eligible for the special enrollment period. For more information on these special enrollment periods, visit:
- https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf
- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html.

- **Disaster Preparedness Toolkit for State Medicaid Agencies:** CMS developed an inventory of Medicaid and CHIP flexibilities and authorities available to states in the event of a disaster. For more information and to access the toolkit, visit:https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html.

- **Dialysis Care:** CMS is helping patients obtain access to critical life-saving services. The Kidney Community Emergency Response (KCER) program has been activated and is working with Quality Insights Renal Network 7, ESRD NW 7, to assess the status of dialysis facilities in the potentially impacted areas related to generators, alternate water supplies, education and materials for patients, and more. They are also assisting patients who have evacuated ahead of the storm to receive dialysis services in the location to which they are evacuating. Patients have been educated to have an emergency supply kit on hand including important personal, medical, and insurance information; contact information for their facility; the ESRD NW hotline number; and contact information of those with whom they may stay or for out-of-state contacts in a water proof bag. They have also been instructed to have on hand supplies to follow a three-day emergency diet. The toll-free hotlines for each NW are: NW 7 – 1-800-826-3773, NW 8 – 1-877-936-9260, and NW 6 – 1-800-524-7139; and the KCER hotline is 866-901-3773. Additional information is available on the NW's websites at https://www.hsag.com/en/esrd-networks/esrd-network-7/, http://esrdnetwork8.org/emergency-preparedness/patients, and https://network6.esrd.ipro.org/home/provider/patient-services/emergency-updates/ or the KCER website www.kcercoalition.com.

- **Medical equipment and supplies replacements:** CMS will temporarily suspend certain requirements necessary for Medicare beneficiaries who have lost or sustained damage to their durable medical equipment, prosthetics, orthotics, and supplies as a result of the hurricane. This will help to make sure that beneficiaries can continue to access the needed medical equipment and supplies they rely on each day. Medicare beneficiaries can contact **1-800-MEDICARE (1-800-633-4227)** for assistance.

- **Suspension of Enforcement Activities:** CMS will suspend current survey and enforcement activities for healthcare facilities in the affected areas of Florida, but will continue to investigate allegations of immediate threat to patient health and safety.

- **Ensuring Access to Care in Medicare Advantage and Part D.** During a PHE, Medicare Advantage Organizations and Part D Plan sponsors must take steps to maintain access to covered benefits for beneficiaries in affected areas. These steps include allowing Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities and waiving, in full, requirements for gatekeeper referrals where applicable.

CMS will continue to work with all geographic areas impacted by Hurricane Michael. We encourage beneficiaries and providers of healthcare services that have been impacted to seek help by visiting CMS' emergency webpage (www.cms.gov/emergency).

To read previous updates regarding HHS activities related to hurricane response and recovery, visit www.phe.gov/emergency.

###

Extraordinary Circumstances Extension / Exception (ECE) due to Hurricane Michael

The purpose of this communication is to notify Post-Acute Care providers of the Centers for Medicare & Medicaid Services (CMS) intent to grant quality reporting data submission and validation exceptions to Medicare providers in several care

settings adversely affected by the devastating impact of Hurricane Michael, including Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Home Health Agencies, and Skilled Nursing Facilities (SNFs). CMS is issuing exceptions for several quality reporting data submission requirements because of possible damage to facilities and/or systems resulting in their inability to gather or submit data, as well as the need to prioritize immediate resources for direct patient care.

Specifically, for the specified reporting quarter(s), as indicated in this communication, affected providers will not be required to submit quality measure data to meet submission requirements.

CMS is exercising its authority to grant exceptions for data submission requirements for the above quality reporting programs for providers located within the Federal Emergency Management Agency (FEMA)-designated "major disaster" counties of Florida, and Georgia listed below:

Florida	**Georgia**	
· Bay	· Baker	· Jefferson
· Calhoun	· Bleckley	· Lee
· Franklin	· Calhoun	· Macon
· Gadsden	· Colquitt	· Miller
· Gulf	· Crisp	· Mitchell
· Hamilton	· Decatur	· Pulaski
· Holmes	· Dodge	· Seminole
· Jefferson	· Dooly	· Sumter
· Jackson	· Dougherty	· Terrell
· Leon	· Early	· Thomas
· Liberty	· Emmanuel	· Treutlen
· Madison	· Grady	· Turner
· Suwannee	· Houston	· Wilcox
· Taylor	· Jefferson	· Worth
· Wakulla		
· Washington		

CMS recommends visiting the FEMA website at https://www.fema.gov for the most up to date list of counties affected by Hurricane Michael. Please note that Medicare providers located outside of the counties covered under this memo, and in need of an extension or exception from program requirements are required to follow the submission process described at the bottom of this memo.

Long Term Care Hospital Quality Reporting Program (QRP)

For the following LTCH QRP requirements and discharged quarters listed below, CMS grants a blanket exception for all LTCHs in the above-designated counties.

LTCHs participating in the CMS LTCH QRP are granted an exception from the data reporting requirements of the LTCH QRP, specifically the data submitted via the LTCH CARE Data Set (assessment-based), and data submitted via the Center for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). Claims-based measures do not require any submission of data to CMS beyond that of data submitted via LTCH PPS claims.

LTCHs located in covered counties are granted an exception from reporting quality data to CMS, as described above, for the following reporting quarters:

- April 1, 2108 – June 30, 2018 (2nd Quarter 2018)
- July 1, 2018 – September 30, 2018 (3rd Quarter 2018)
- October 1, 2018 – December 31, 2018 (4th Quarter 2018) For the following IRF QRP requirements and discharged quarters listed below, CMS grants a blanket exception for all IRFs in the above-designated counties.

Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)

For the following IRF QRP requirements and discharged quarters listed below, CMS grants a blanket exception for all IRFs in the above-designated counties.

IRFs participating in the CMS IRF QRP are granted an exception from the data reporting requirements of the IRF QRP, specifically the data submitted via the assessment-based IRF-PAI (Patient Assessment Instrument) and data submitted via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). Claims-based measures do not require any submission of data to CMS beyond that of data submitted via IRF PPS claims. **Please note that this exception applies to quality data only, and has no effect on the submission of the IRF-PAI for payment purposes.**

IRFs located in covered counties are granted an exception from reporting quality data to CMS, as described above, for the following reporting quarters:

- April 1, 2108 – June 30, 2018 (2nd Quarter 2018)
- July 1, 2018 – September 30, 2018 (3rd Quarter 2018)
- October 1, 2018 – December 31, 2018 (4th Quarter 2018)

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

For the following SNF QRP requirements and discharged quarters listed below, CMS grants a blanket exception for all SNFs in the above-designated counties.

SNFs participating in the CMS SNF QRP are granted an exception from the data reporting requirements of the SNF QRP, specifically the data submitted via the assessment-based Minimum Data Set (MDS). Claims-based measures do not require any submission of data to CMS beyond that of data submitted via Medicare FFS claims. **Please note that this exception applies to quality data only, and has no effect on the submission of the MDS for payment or other required purposes.**

SNFs located in covered counties are granted an exception from reporting quality data to CMS, as described above, for the following reporting quarters:

- April 1, 2108 – June 30, 2018 (2nd Quarter 2018)
- July 1, 2018 – September 30, 2018 (3rd Quarter 2018)
- October 1, 2018 – December 31, 2018 (4th Quarter 2018)

Hospice Quality Reporting Program (QRP)

For the following Hospice QRP requirements and discharged quarters listed below, CMS grants a blanket exception for all Hospices in the above-designated counties.

Hospices participating in the CMS Hospice QRP are granted an exception from the data reporting requirements of the Hospice QRP, specifically the data submitted via the Hospice Item Set (HIS) and the Hospice Consumer Assessment of Healthcare Providers and Systems (Hospice CAHPS®) survey. The CAHPS Hospice Survey exception will apply to "Q3 2018 and Q4 2018 decedents," or hospice patients who died between July-December 2018

Hospices located in covered counties are granted an exception from reporting quality data to CMS, as described above, for the following reporting quarters:

- July 1, 2018 – September 30, 2018 (3rd Quarter 2018)
- October 1, 2018 – December 31, 2018 (4th Quarter 2018)

Home Health Agencies Quality Reporting Program

For the following HH QRP requirements and discharged quarters listed below, CMS grants a blanket exception for all HHAs in the above-designated counties.

HHAs participating in the CMS HH QRP are granted an exception from the data reporting requirements of the HH QRP, specifically the data submitted via the OASIS assessment instrument and Home Health Consumer Assessment of Providers and Systems Survey (HH CAHPS®). Please **note that this exception applies to quality data only, and has no effect on the submission of the Home Health OASIS for payment purposes**

HHAs located in covered counties are granted an exception from reporting quality data to CMS, as described above, for the following reporting quarters:

- July 1, 2018 – September 30, 2018 (3rd Quarter 2018)
- October 1, 2018 – December 31, 2018 (4th Quarter 2018)

We would like to note that this exception from quality reporting requirements for the above-listed CMS QRPs may impact the minimum case threshold counts for calculation of quality metrics. While you can continue to submit data to CMS, any data submissions for the above-listed exempt CY 2018 quarters will not be considered when determining compliance related to the FY 2020 reporting requirements for your hospital or facility. That is, you will not be held accountable for quality data collected and submitted during the 2018 quarters identified above. Please also note that this may affect the minimum amount of data needed to calculate specific quality measures for public reporting purposes, in which case CMS would suppress the applicable data on the respective Compare sites, when quality measure data are calculated and posted.

Exception and Extension Request Process

Hospitals and Facilities in other counties and states may submit ECE Requests for data submission based on individual circumstances by one of the following processes:

- LTCH QRP: For LTCHs outside the FEMA-designated counties listed above in this notice, that were affected by Hurricane Michael, please follow the directions related to requesting an exception, as listed on the LTCH Quality Reporting Reconsideration and Exception & Extension website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Reconsideration-and-Exception-and-Extension.html or email questions to LTCHQRPReconsiderations@cms.hhs.gov.
- IRF QRP: For IRFs outside the FEMA-designated counties listed above in this notice, that were affected by Hurricane Michael, please follow the directions related to requesting an exception as listed on the IRF Quality Reporting Reconsideration and Exception & Extension website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Reconsideration-and-Exception-and-Extension.html or email questions to IRFQRPReconsiderations@cms.hhs.gov.
- SNF QRP: For SNFs outside the FEMA-designated counties listed above in this notice, that were affected by Hurricane Michael, please follow the directions related to requesting an exception as listed on the SNF Quality Reporting Reconsideration and Exception & Extension website at https://www.cms.gov/Medicare/Quality-

Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-QR-Reconsideration-and-Exception-and-Extension.htmlor email questions to SNFQRPReconsiderations@cms.hhs.gov.

- Hospice QRP: For Hospice providers outside the FEMA-designated counties listed above in this notice, that were affected by Hurricane Michael, please follow the directions related to requesting an exception, as listed on the Hospice Quality Reporting Exception & Extension website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Extensions-and-Exception-Requests.html or email questions to HospiceQRPReconsiderations@cms.hhs.gov.

Home Health QRP: For HHAs outside the FEMA-designated counties listed above in this notice, that were affected by Hurricane Michael, please follow the directions related to requesting an exception, as listed on the HHA Quality Reporting Reconsideration and Exception and Extension web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Reconsideration-and- Exception-and-Extension.html

###

CMS Acts to Help with Typhoon Yutu Emergency Response

Agency waivers to take effect in the Northern Mariana Islands

The Centers for Medicare & Medicaid Services (CMS) today announced that the agency has acted to support the Northern Mariana Islands in response to Typhoon Yutu. This week, Health and Human Services Secretary Alex Azar declared a public health emergency (PHE) in the Northern Mariana Islands. With the PHE in effect, CMS has taken several actions to provide immediate relief to those impacted by the typhoon. The actions will include temporarily waiving or modifying certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements; creating special enrollment opportunities for individuals to access healthcare immediately; and taking steps to ensure dialysis patients obtain critical life-saving services.

"Our thoughts are with all affected by this devastating typhoon," Administrator Seema Verma said. "CMS has taken the measures necessary to help support everyone that could be impacted. The waivers that will be in effect in the Northern Mariana Islands will give healthcare providers, facilities, and suppliers the flexibility to provide continued access to care in the wake of this unprecedented storm. We will continue to monitor the destruction caused by the typhoon and work closely with officials in the Northern Mariana Islands."

Below are key administrative actions CMS is taking in response to the PHE declared in the Northern Mariana Islands:

- **Waivers for Hospitals, Healthcare Facilities, and Clinicians:** CMS will be temporarily waiving or modifying certain Medicare, Medicaid, and CHIP requirements. CMS will be issuing a number of waivers as necessary, which will be listed on the website below, and the CMS Regional Office will be granting other provider-specific requests for specific types of hospitals and other facilities in the Northern Mariana Islands. These waivers work to provide continued access to care for beneficiaries. For more information on the waivers CMS will grant, visit: www.cms.gov/emergency.
- **Special Enrollment Opportunities for Individuals Impacted by the Typhoon:** CMS has made special enrollment periods available for all Medicare beneficiaries. This gives people impacted by the typhoon the opportunity to change their Medicare health and prescription drug plans immediately if eligible for the special enrollment period. For more information on these special enrollment periods, visit: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html.
- **Disaster Preparedness Toolkit for State Medicaid Agencies:** CMS developed an inventory of Medicaid and CHIP flexibilities and authorities available to states in the event of a disaster. For more information and to access the toolkit, visit: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html.
- **Dialysis Care:** CMS is helping patients obtain access to critical life-saving services. The Kidney Community Emergency Response (KCER) program has been activated and is working with HSAG ESRD Network 17 to assess the status of dialysis facilities in the potentially impacted areas related to generators, alternate water supplies, education and materials for patients, and more. The toll-free hotline for Network 17 is 1-800-232-3773 and the KCER hotline is 866-901-3773. Additional information is available on the Network 17 website at https://www.hsag.com/en/esrd-networks/esrd-network-17/emergency-preparedness/, or the KCER website https://www.kcercoalition.com/en/patients/

- **Medical equipment and supplies replacements:** CMS will temporarily suspend certain requirements necessary for Medicare beneficiaries who have lost or sustained damage to their durable medical equipment, prosthetics, orthotics, and supplies as a result of the hurricane. This will help to make sure that beneficiaries can continue to access the needed medical equipment and supplies they rely on each day. Medicare beneficiaries can contact 1-800-MEDICARE (1-800-633-4227) for assistance.
- **Suspension of Enforcement Activities:** CMS will suspend current survey and enforcement activities for healthcare facilities in the affected areas of Georgia, but will continue to investigate allegations of immediate threat to patient health and safety.
- **Ensuring Access to Care in Medicare Advantage and Part D.** During a PHE, Part D Plan sponsors must take steps to maintain access to covered benefits for beneficiaries in affected areas.
- **Provider Enrollment:** CMS will temporarily waive and streamline provider enrollment requirements when enrolling providers to prevent a disruption in services to Medicaid and CHIP beneficiaries.

CMS will continue to work with all areas impacted by Typhoon Yutu. We encourage beneficiaries and providers of healthcare services that have been impacted to seek help by visiting CMS' emergency webpage (www.cms.gov/emergency).

To read previous updates regarding HHS activities related to natural disaster response and recovery efforts, visit www.phe.gov/emergency.

###

CMS Model Addresses Opioid Misuse Among Expectant and New Mothers

Goals are to improve quality of care, increase access to treatment based on state-specific needs, and reduce expenditures

The Centers for Medicare & Medicaid Services (CMS) announced the Maternal Opioid Misuse (MOM) model, an important step in advancing the agency's multi-pronged strategy to combat the nation's opioid crisis. The model addresses the need to better align and coordinate care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state-driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the MOM model has the potential to improve quality of care and reduce expenditures for mothers and infants.

"Too many barriers impede the delivery of well-coordinated, high-quality care to pregnant and postpartum women struggling with opioid misuse, including lack of access to treatment and a shortage of providers in rural areas, where the opioid crisis is especially destructive," said HHS Secretary Alex Azar. "The MOM model will support state Medicaid agencies, front-line providers and healthcare systems to help ensure that mothers and infants afflicted by the opioid epidemic get the care they need."

Substance use-related illness and death is now a leading cause of maternal death. Pregnant and postpartum women who misuse substances are at high risk for poor maternal outcomes, including preterm labor and complications related to delivery; these problems are frequently exacerbated by malnourishment, interpersonal violence, and other health-related social needs. Infants exposed to opioids before birth are at greater risk for negative health outcomes such as higher risk of being born preterm, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome (NAS), a group of conditions caused when an infant withdraws from certain drugs s/he is exposed to in the womb. In addition, Medicaid pays the largest portion of hospital charges for maternal substance use, as well as a majority of the $1.5 billion annual cost of NAS.

The primary goals of the model are to:

- Improve quality of care and reduce expenditures for pregnant and postpartum women with OUD as well as their infants;
- Increase access to treatment, service-delivery capacity, and infrastructure based on state-specific needs; and
- Create sustainable coverage and payment strategies that support ongoing coordination and integration of care.

The CMS Innovation Center will execute up to 12 cooperative agreements with states, whose Medicaid agencies will implement the model with one or more "care-delivery partners" in their communities. The MOM model will serve pregnant Medicaid and Children's Health Insurance Program (CHIP) beneficiaries with OUD who have elected to participate, during the prenatal, peripartum (i.e., surrounding labor and delivery), and postpartum periods. Awardees will be responsible for ensuring that beneficiaries participating in the model have access to a set of essential physical and behavioral health services, such as medication-assisted treatment (MAT) for OUD, maternity care, relevant primary care services, and other mental and behavioral health services beyond MAT.

The MOM model will have a five-year period of performance with different types of funding. Specifically, implementation funding, transition funding, and the opportunity for milestone funding will be provided in three distinct model periods: Pre-implementation (Year 1), Transition (Year 2), and Full Implementation (Years 3-5).

Care delivery will begin in Year 2, or the Transition Period, of the model. During this year, funding for care-delivery services that are not otherwise covered by Medicaid will be provided by Innovation Center funds. By Year 3, the start of the Full Implementation Period, states must implement coverage and payment strategies. This overall structure seeks to balance rapid model initiation and state flexibility, while minimizing administrative burden. In particular, the MOM model design supports each awardee's ability to quickly begin delivering coordinated and integrated care to pregnant and postpartum women with OUD during the Transition Period, while supporting states in developing a long-term coverage and payment strategy that aligns with their state Medicaid program.

CMS anticipates releasing a Notice of Funding Opportunity (NOFO) in early 2019 to solicit cooperative agreement applications to implement the MOM model. The state Medicaid agency will be expected to complete the application, which must demonstrate that it has partnered with at least one care-delivery partner. A maximum of $64.6 million will be available across up to 12 state awardees over the course of the five-year model. The NOFO will contain all model requirements and eligibility criteria for potential applicants.

In August, CMS announced the Integrated Care for Kids (InCK) Model, a child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and CHIP through prevention, early identification, and treatment of priority health concerns like behavioral health challenges, including substance abuse. The model will empower states and local providers to better address these needs through care integration across all types of healthcare providers. CMS anticipates releasing a NOFO for the InCK Model at the same time as it does for the MOM Model.

For more information, please visit https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/ or the fact sheet: https://www.cms.gov/sites/drupal/files/2018-10/10-23-2018%20Fact%20Sheet%20Maternal%20Opioid%20Misuse%20%28MOM%29%20Model%20%28FINAL%29.pdf

###

CMS Proposes to Require Manufacturers to Disclose Drug Prices in Television Ads

Proposed rule would further the Trump Administration's commitment to lower prescription drug prices by requiring companies to list prices for prescription drugs covered in Medicare or Medicaid

As part of the agency's ongoing efforts to empower patients and lower prescription drug prices, the Centers for Medicare & Medicaid Services proposed today to require that prescription drug manufacturers post the Wholesale Acquisition Cost (WAC) for drugs covered in Medicare or Medicaid in direct-to-consumer television advertisements.

"This historic proposal is an important way to create new incentives for drug companies to start lowering their list prices, rather than raising them," said HHS Secretary Alex Azar. "President Trump's drug-pricing blueprint called for HHS to consider how to accomplish this goal, and now we are following through on this measure to better inform patients, help them lower their drug costs, and reduce unreasonable spending in Medicare and Medicaid."

The proposed rule would work to inject greater transparency into the prices prescription drug manufacturers set and would give beneficiaries important information they need to make informed decisions based on cost, while concurrently providing a moderating force to counteract price increases.

"President Trump and Secretary Azar are working tirelessly to bring down prescription drug prices, and today CMS is continuing to execute on the President blueprint," said CMS Administrator Seema Verma. "We are committed to price transparency across-the-board, and prescription drugs are no different. Patients often pay their cost-sharing or deductible off of a drug's list price. Today's proposed rule would ensure that those list prices are included in television advertisements, so patients have the information they need to make informed decisions."

Under the proposed rule, the price required to be posted would be for a typical course of treatment for an acute medication like an antibiotic, or a thirty day supply of medication for a chronic condition that is taken every month, and the posting would take the form of a legible textual statement at the end of the ad. The HHS Secretary would maintain a public list of drugs that were advertised in violation of this rule. CMS would provide an exception to the requirement to post prices for prescription drugs with list prices of less than $35 per month.

Additionally, to advance the Administration's goal to ensure drug price transparency and also account for the different ways Americans receive advertising and promotional messages, CMS is seeking comment on whether the regulation should apply to advertisements in other media forms such as radio, magazines, newspapers, websites, and social networking sites.

Today's announcement further strengthens CMS's commitment to pull back the curtain on the system of drug pricing. Earlier this year, CMS released a redesigned version of the Drug Spending Dashboards which include year-over-year information on drug prices and, for the first time, highlight which manufactures have been increasing their prices. This move was an important step to bringing transparency and accountability to a process largely hidden from patients.

The agency has also taken action to promote transparency in other areas of the healthcare system, such as by requiring hospitals to post their standard charges online in a machine-readable format. In addition, CMS recently launched the eMedicare initiative to empower beneficiaries with cost and quality information. This announcement included the launch of a mobile-optimized out-of-pocket cost calculator that will provide beneficiaries with information on both overall plan costs and prescription drug costs.

For a policy brief on the Drug Pricing Transparency CMS-4187 proposed rule, please visit: https://www.hhs.gov/about/news/2018/10/15/what-you-need-to-know-about-putting-drug-prices-in-tv-ads.html

The proposed rule can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection/.

CMS looks forward to feedback on the proposal and will accept comments until December 17, 2018. Comments may be submitted electronically through our e-Regulation website https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking.

###

CMS Proposes to Modernize Medicare Advantage, Expand Telehealth Access for Patients

Proposed rule would strengthen the popular system for private health insurance plans to provide Medicare coverage, increase plan flexibility to offer telehealth benefits, and improve coordination for dual-eligible beneficiaries

In a proposed rule issued, the Centers for Medicare & Medicaid Services (CMS) took action to build upon the Administration's ongoing efforts to modernize the Medicare Advantage and Part D programs, which provide seniors with Medicare health and prescription drug coverage through private plans. The changes proposed today would allow plans to cover additional telehealth benefits and would make other much-needed updates, including for individuals who are eligible for Medicare Advantage special needs plans.

"President Trump is committed to strengthening Medicare, and an increasing number of seniors are voting with their feet and choosing to receive their Medicare benefits through private plans in Medicare Advantage. Today's proposed changes would give Medicare Advantage plans more flexibility to innovate in response to patients' needs," said CMS Administrator Seema Verma. "I am especially excited about proposed changes to allow additional telehealth benefits, which will promote access to care in a more convenient and cost-effective manner for patients."

Medicare Open Enrollment for 2019 is currently underway and runs through December 7, 2018, so seniors can review their coverage options and decide how they would like to receive their Medicare benefits in 2019. CMS offered new flexibilities to Medicare Advantage plans starting in the 2019 plan year, and plans are making additional benefits available including adult day care services, in-home support services, and benefits tailored for patients with chronic diseases like diabetes.

The average Medicare Advantage premium will decline by 6.1 percent, enrollment is projected to grow by 11.5 percent, and there will be approximately 600 more plans available across the country next year.

Today's proposed changes for plan year 2020 would leverage new authorities provided to CMS in the Bipartisan Budget Act of 2018, which President Trump signed into law earlier this year. With respect to telehealth, the proposed changes would remove barriers and allow Medicare Advantage plans to offer "additional telehealth benefits" not otherwise available in Medicare to enrollees, starting in plan year 2020 as part of the government-funded "basic benefits."

This proposal will allow Medicare Advantage plans broader flexibility in how coverage of telehealth benefits is paid to meet the needs of their enrollees. As Medicare beneficiaries become more tech savvy, CMS is working across the agency to promote beneficiary access to telehealth, but the Medicare fee-for-service program telehealth benefit is narrowly defined and includes restrictions on where beneficiaries receiving care via telehealth can be located. The proposed rule would give MA plans more flexibility to offer government-funded telehealth benefits to all their enrollees, whether they live in rural or urban areas. It would also allow greater ability for Medicare Advantage enrollees to receive telehealth from places like their homes, rather than requiring them to go to a health care facility to receive telehealth services. Plans would also have greater flexibility to offer clinically-appropriate telehealth benefits that are not otherwise available to Medicare beneficiaries.

Today's proposed changes are a major step towards expanding access to telehealth services because the rule would eliminate barriers for private Medicare Advantage plans to cover such additional telehealth benefits under the MA plan. While MA plans have always been able to offer more telehealth services than are currently payable under original Medicare through supplemental benefits, this change in how such additional telehealth benefits are financed (that is, accounted for in payments to plans) makes it more likely that MA plans will offer them and that more enrollees will be able to use the benefits.

Additional changes proposed today would improve the quality of care for dually-enrolled beneficiaries in Medicare and Medicaid who participate in "Dual Eligible Special Needs Plans" or D-SNPs. These beneficiaries generally have complex health needs. Today's proposed changes would unify appeals processes across Medicare and Medicaid to make it easier for enrollees in certain D-SNPs to navigate the system. The proposed rule would also require plans to more seamlessly integrate benefits across the two programs to promote coordination.

Today's proposed rule also improves accountability and bolsters program integrity within the Medicare Advantage and Part D programs. The proposed changes would update the methodology for calculating Star Ratings, which provide information to consumers on plan quality. The new methodology would improve stability and predictability for plans, and would adjust how the ratings are set in the event of extreme and uncontrollable events such as hurricanes.

The proposed rule also includes critical updates with respect to program integrity. First, CMS is making revisions to an earlier regulation that made available to Part D sponsors and Medicare Advantage plans a list of precluded providers and prescribers that have engaged in behavior that bars their enrollment in Medicare. Under the earlier regulation, plans would be required to deny payment for any prescription, service, or item that is prescribed or furnished by an individual or entity on the Preclusion List.

Second, the proposed rule would take steps to help CMS recover improper payments made to Medicare Advantage organizations. CMS conducts Risk Adjustment Data Validation audits to confirm that diagnoses submitted by Medicare Advantage Organizations for risk adjusted payments are supported by medical record documentation. CMS recovers improper payments based on these audits. The proposed rule would strengthen CMS's ability to return dollars to the Medicare Trust Funds as a result of these audits. If finalized, the proposed changes would result in an estimated $4.5 billion in savings to the Medicare Trust Funds over a ten year period, largely from the recovery of improper payments to Medicare Advantage plans through contract- level Risk Adjustment Data Validation audits. In addition, CMS released an analysis on the application of a Fee-For-Service adjuster in determining the Medicare Advantage payment recoveries. The analysis can be accessed at: https://www.cms.gov/Research-Statistics-Data-and- Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation- Program/Resources.html (the Fee-For-Service Adjuster executive summary and technical appendix are available in the "Downloads" section of the webpage).

For a fact sheet on the CY 2020 Medicare Advantage and Part D Flexibility Proposed Rule (CMS-4185-P), please visit: https://www.cms.gov/newsroom/fact-sheets/contract-year-cy-2020- medicare-advantage-and-part-d-flexibility-proposed-rule-cms-4185-p.

The proposed rule can be downloaded from the Federal Register at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23599.pdf

And on 11/01/2018 and available online at https://federalregister.gov/d/2018-23599

CMS looks forward to feedback on the proposal and will accept comments until December 31, 2018. Comments may be submitted electronically through our e-Regulation website at: https://www.cms.gov/Regulations-and-Guidance/Regulations-and- Policies/eRulemaking/index.html?redirect=/eRulemaking.

###

Upcoming Webinars and Events and Other Updates

Congressional Tele-town Hall Events for Medicare Beneficiaries

Various congressional offices in Region 7 (Kansas, Iowa, Missouri and Nebraska) are hosting Medicare Tele-town events. The staff at the Kansas City Regional Office for the Centers for Medicare & Medicaid Services (CMS), would like to offer our assistance to your office with these events over the next few weeks when Medicare constituents and their families have a piqued interest in this topic as Medicare Open Enrollment is October 15 – December 7, 2018. Our staff is available to assist you with answering questions from your constituents. As the CMS Regional office will be busy with various aspects of this campaign and other work, we ask that you give us a least a week notification to schedule staff to participate. Contact Julie Brookhart at Julie.Brookhart@cms.hhs.gov.

###

CMS National Training Program Learning Series Webinar

November 8, 2018 1:00 – 2:30 pm ET

This webinar will provide an overview of Medicare Supplement Insurance (Medigap) policies including:

- What Medigap policies are
- Key Medigap terms
- Changes to Medigap Plans in 2020
- Steps to buying a Medigap policy
- The best time to buy a Medigap policy
- Guaranteed issue rights
- Where to get more information

To register for the webinar: Visit cmsnationaltrainingprogram.cms.gov/moodle/course/view.php?id=31.

###

Medicare's Open Enrollment Period is October 15 - December 7

Medicare health and drug plans can make changes each year—things like cost, coverage, and what providers and pharmacies are in their networks. October 15 to December 7 is when all people with Medicare can change their Medicare health plans and prescription drug coverage for the following year to better meet their needs. To find 2019 health and drug plans, compare coverage options, or to estimate Medicare costs, go to Medicare.gov. You can also find Medicare Open Enrollment Period outreach and media materials here.

###

NEW NTP Self-Paced Course

Automatic enrollment in Medicare: Part A & Part B

You'll learn when Medicare enrollment is automatic. In the past, typical ages for Medicare and Social Security benefits enrollment were the same. Now, that has changed. This is why people don't always know they may need to take an action

to get Medicare, or if they can expect to be automatically enrolled. You'll help people who are eligible for enrollment know if it'll be automatic for them, and inform them about the decisions they may need to make based on their circumstances.

Enroll in the course now. You'll first be prompted to create a user account if you haven't done so already. After that, you can launch the course. Check back often as we plan to add more courses in the future.

###

CMS Hospital/Quality Initiative Open Door Forum

Tuesday November 13, 2018 2:00pm-3:00pm Eastern Time (ET)

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

This Agenda is Subject to Change

I. Opening Remarks

Chair – Tiffany Swygert (Center for Medicare)

Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- CY 2019 Hospital Outpatient Prospective System/Ambulatory Surgical Center Payment System Final Rule—Highlights
- Requirement for Hospitals To Make Public a List of Their Standard Charges via the Internet

- IRF National Provider Call Announcement
    - Register for Medicare Learning Network events.

- Reminder: Providers to review MLN Special Edition Article 18023
    - The article is now available at:
    - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18023.pdf

III. Open Q&A

DATE IS SUBJECT TO CHANGE

Next CMS Hospital/Quality Initiative Open Door Forum: TBD

ODF EMAIL MAILBOX: Hospital_ODF@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 & Reference Conference ID: 35530114

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: 35530114

Encore 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 2 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 and understands 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. **

###

Register for November 15 Quality Payment Program Year 3 Final Rule Overview Webinar

The Centers for Medicare & Medicaid Services (CMS) is hosting a webinar on **Thursday, November 15, 2018 at 12:00 PM ET** to provide information about the final rule for Year 3 (2019) of the Quality Payment Program.

During the webinar, CMS subject matter experts will:

- Provide an overview of the Quality Payment Program, Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs)
- Discuss Year 3 MIPS and Advanced APM policy changes
- Highlight key differences between Year 2 and Year 3 requirements
- Review ways to connect to the no-cost technical assistance and identify additional resources where attendees can learn more.

Webinar Details

Title: Quality Payment Program Year 3 (2019) Final Rule Overview Webinar

Date: Thursday, November 15, 2018

Time: 12:00 – 1:30 p.m. ET

Registration Link: https://engage.vevent.com/rt/cms/index.jsp?seid=1288

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

###

New / Updated Training Materials

- 2018 Module 0 Getting Started With Medicare (Spanish)
- 2018 Module 2 Medicare Rights and Protections (Spanish)
- 2018 Module 6 Medicare For People With ESRD (Spanish)
- Medicare Job Aids: Standard Drug Benefit

###

New / Updated CMS Publications

- Protecting Medicare and You from Fraud
- Medicare Coverage of Diabetes Supplies & Services
- How Medicare Drug Plans Use Pharmacies, Formularies, & Common Coverage Rules
- Medicare: Getting Started
- Are You a Hospital Inpatient or Outpatient? If you have Medicare – Ask!
- 4R's for Fighting Medicare Fraud
- Welcome to Medicare: Important decisions after signing up for Medicare

###

Did You Know?

The **NEW eMedicare initiative** will modernize the way people with Medicare get information about Medicare and create new ways to help them make the best decisions for themselves and their families. Learn more by checking out the eMedicare press release, blog, and video.

October is **Breast Cancer Awareness Month**. To learn more about breast cancer symptoms, risk factors and screening, visit CDC.gov/cancer/breast/. A mammogram is a preventive screening that is covered by Medicare Part B. For more information, visit Medicare.gov/coverage/mammograms.html.

###

Medicare Learning Network

News & Announcements

- New Medicare Card: Destroy the Old Card
- CMS to Strengthen Oversight of Medicare's Accreditation Organizations
- Participants in New Value-Based Bundled Payment Model
- Medicare Diabetes Prevention Program: New Covered Service
- Part A Providers: MCReF System Enhancement
- Protect Your Patients from Influenza this Season
- HHS Advances Payment Model to Lower Drug Costs for Patients
- SNF Quality Reporting Program Data on Nursing Home Compare
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline November 15
- Hospital Cost Report Data: User-Friendly Version
- Medicare Diabetes Prevention Program: New Covered Service
- November is Home Care and Hospice Month

Provider Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder
- Ophthalmology Services: Questionable Billing and Improper Payments — Reminder

Claims, Pricers & Codes

- Reprocessing Claims for Diagnostic Services by Certain PTs

Upcoming Events

- IRF Payment and Coverage Policies: FY 2019 Final Rule Call — November 15

Medicare Learning Network® Publications & Multimedia

- LCDs MLN Matters Article — New
- Ensuring OC 22 is Billed Correctly on SNF Inpatient Claims MLN Matters Article — New
- HCPCS Codes for SNF CB: 2019 Annual Update MLN Matters Article — New
- Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New
- Medicare Preventive Services National Educational Products Listing — Revised
- Typhoon Yutu and Medicare Disaster Related Commonwealth of the Northern Mariana Islands Claims MLN Matters Article — New
- MRI MLN Matters Article — New
- Incomplete Colonoscopies Billed with Modifier 53 MLN Matters Article — New
- CWF Edit of MA Inpatient Claims from Approved Teaching Hospitals MLN Matters Article — New
- Correction to CWF IUR 7272 for Intervening Stay MLN Matters Article — New
- Redesign of Hospice Periods MLN Matters Article — New
- ASP Medicare Part B Drug Pricing Files and Revisions: January 2019 MLN Matters Article — New
- MCReF System Webcast: Audio Recording and Transcript — New
- Patient Relationship Categories and Codes Webcast: Audio Recording and Transcript — New
- Medicare Podiatry Services Fact Sheet — Revised
- Medicare and Medicaid Basics Booklet — Revised

###

NIDA's New Opioid Facts for Teens

NIDA recently released **Opioid Facts for Teens**, a resource that provides teens with FAQs about opioids, opioid overdose, and opioid use disorder treatment options.

https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/patient-materials

###

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.