

CMS Region 7 Updates

09/30/2016

ACA/Marketplace Updates

IRS Data: A Closer Look Into The Individual Mandate

The Internal Revenue Service (IRS) recently published [national, county-level, and zip code](#) data on tax filings for 2014. The data, in part, showed that 8.1 million taxpayers (or 5.9 percent of individual tax filers) paid the penalty for failing to have minimum essential coverage for the year. This information may be helpful to identify geographic areas where a lot of people paid the penalty and may still be uninsured.

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Marketplace Young Adults Announcement

As the White House convenes the [Millennial Outreach and Enrollment Summit](#), the Centers for Medicare and Medicaid Services (CMS) announced additional initiatives to reach young adults during Open Enrollment and help them find affordable coverage through HealthCare.gov. Young adults had the highest uninsured rates before the Affordable Care Act and have seen the sharpest drop in uninsured rates since 2010. Yet millions of young adults remain uninsured, showing that there is more work to do to equip younger Americans with the tools and information they need to access coverage through the Health Insurance Marketplace. We are announcing new strategies, new tools, and new partnerships to reach young people and help them get covered.

“[More than 9 in 10](#) Marketplace-eligible young adults without health insurance have incomes that could qualify them for tax credits to make plans affordable, but that fact hasn’t fully penetrated the millennial community, and we want to change that,” said Kevin Counihan, HealthCare.gov CEO. “This year, we’ll be using new tactics and strategies to reach young adults where they are and deliver the message that they have affordable coverage options. These new tactics will both benefit young Americans and strengthen the Marketplace risk pool.”

New Digital Platforms

For the first time, Open Enrollment outreach will take advantage of online platforms that cater almost exclusively to young adults. We are announcing the first of these new efforts: outreach utilizing Twitch, a social video platform and community for gamers. This effort will feature [HealthCare.gov](#) pre-roll before videos, a homepage takeover, and ongoing efforts with streamers on Twitch to amplify our message throughout Open Enrollment. **Twitch currently attracts close to 10 million daily active users** who, on average, spend 106 minutes per person per day on the site. According to ComScore, Twitch’s core demographic of 18-34 year-olds have above average uninsured rates.

Mobile 2.0

According to [ComScore](#), 1 in 5 millennials access the internet exclusively through mobile devices. Last year, consumers could easily enroll in coverage at HealthCare.gov through mobile devices, but if they

wanted to actually shop around and compare plans, the mobile interface could be difficult and time consuming. This year, consumers will find an end-to-end, mobile optimized experience, including a new state-of-the-art shopping process that **for the first time offers improved ability to comparison shop on their phone or tablet.** Rather than clicking on tiny boxes or zooming in on hard-to-read screens, consumers will now find intuitive navigation and a streamlined interface to compare plans.

Targeted and Coordinated Partner Campaigns

During 2017 Open Enrollment, CMS and stakeholders will organize a young adult **social media outreach campaign under one umbrella: #HealthyAdulting.** As part of this coordinated campaign, longstanding Open Enrollment partners will be stepping up their social media engagement and will coordinate with each other to maximize the impact of that social media work in driving enrollment. CMS will be joining with partners to communicate with young people on the digital platforms they prefer – including Facebook, Twitter, and Tumblr – and engaging in a conversation under a unified #HealthyAdulting message about issues young people care about, whether that’s mental health, women’s wellness, reproductive health, or diabetes prevention.

Together, partners in the #HealthyAdulting campaign reach almost **five million social media followers,** meaning trusted voices will be raising awareness about Open Enrollment among young adults. Participating organizations include: The American Congress of Obstetricians and Gynecologists, American Diabetes Association, American Hospital Association, American Medical Student Association, the League of United Latin American Citizens, Mental Health America, Autism Speaks, March of Dimes, Mocha Moms, My Halal Kitchen, National Council of La Raza, National Action Network, National Partnership for Women & Families, the National Latina Institute for Reproductive Health, National Women’s Law Center, Out2Enroll, Planned Parenthood Federation of America, Raising Women’s Voices, Truth Initiative, the United Methodist Church, and Young Invincibles. Specific social media activities our partners are planning include:

- *National Council of La Raza* will engage their 56,600 Twitter followers by hosting a twitter storm supported by the *League of United Latin American Citizens* targeting young millennial Latinos and immigrants to discuss the value proposition of healthcare.
- The *National Action Network*, a leading civil rights organization founded by Reverend Al Sharpton, will engage their over 500,000 followers using #HealthyAdulting to reach out to young adults.
- *March of Dimes* will host a Facebook Chat for its 630,000 followers about prenatal care and preventive services covered as essential benefits under Marketplace plans.
- The *Planned Parenthood Federation of America* will engage their 837,000 followers in a Facebook live-stream led by the National Latina Institute for Reproductive Health addressing the state of Latina health.

Meanwhile, we are also introducing new partnerships for 2017 with partners that have strong social media followings among young adults. Examples of new partnerships in 2017 include:

- *Tumblr* will produce and promote a #HealthyAdulting event that will brand the movement of young adults taking ownership of their health and life choices by gaining health insurance and taking advantage of preventive services and wellness visits.
- *My Halal Kitchen* will host Facebook conversations for its 1.3 million followers about healthy living, mental and emotional wellness, and heart health.

- *Autism Speaks* will engage its 217,000 Twitter followers by hosting a Twitter chat on the prevalence of autism among young adults, autism screening as a covered benefit, and additional resources the community can use to get the best care.

Collaborating with Federal Partners and Programs

As we get closer to Open Enrollment, we are also working with federal partners to reach people enrolled in their programs who may need and want Marketplace coverage, with a particular focus on reaching young adults. We are announcing two new efforts:

- **The Department of Defense** will include information about the Marketplace in the Transition Assistance Program, Transition GPS (Goals, Plans, Success) curriculum; more specifically, in the Personal Financial Planning module. The program, run through the Defense Transition Assistance Program Office, will inform transitioning Service members about health insurance options for their family, including HealthCare.gov coverage and possibility of qualifying for Marketplace financial assistance. Since this course is continually being offered, many Service members will lose their military coverage outside of Open Enrollment but would be eligible to sign up for Marketplace coverage through a special enrollment period. Approximately 200,000 transitioning Service members, many of whom are under the age of 35, will receive this information annually.
- **The Medicaid and Children's Health Insurance Programs (CHIP)** will work in coordination with HealthCare.gov to get more and better information to young adults aging out of these programs at age 19, to others exiting Medicaid or CHIP coverage, and to people who apply for these programs but have incomes too high to qualify. Federal law requires states to transfer these individuals' account information from Medicaid or CHIP to the Health Insurance Marketplace, but the Marketplace has had limited ability to conduct outreach to this group to date. New this year, the Marketplace will be able to contact millions of these individuals via email and mail, and provide information about financial assistance and Marketplace coverage options during Open Enrollment. Almost half of the individuals in this group are age 18-34. In addition, CMS will be releasing new guidance for states outlining best practices for communicating with individuals leaving Medicaid or CHIP and for sharing information with the Marketplace to facilitate direct outreach and to make it easier for individuals to complete a Marketplace application using information they have already provided to their state Medicaid or CHIP program.

In addition, as [previously announced](#), **the Internal Revenue Service will conduct new outreach this year to uninsured people who paid the individual responsibility penalty or claimed an exemption**, letting them know that tax credits are available for Marketplace coverage and providing information about their health coverage options. Young adults are overrepresented among those who paid the fee: about 45 percent of taxpayers paying a penalty or claiming an exemption were under age 35, compared to about 30 percent of all taxpayers in 2014. [Experts](#) have suggested reaching out to those who paid the fee or claimed an exemption to make sure they are aware of their options to enroll in coverage, an approach already implemented in Massachusetts.

We're putting the finishing touches on our plans for Open Enrollment 4. Between now and November 1, you'll see a series of announcements from us about what's new, what's better, and what to expect during this

Open Enrollment – including new tools for consumers, new outreach tactics and targeting strategies, and more information about continued access to affordable coverage.

Americans can sign up for affordable health plans that meet their needs and their budgets at HealthCare.gov or their [state Marketplace websites](#) beginning November 1. Open Enrollment runs through January 31, 2017. Health coverage can start as soon as January 1, 2017 for consumers who sign up by December 15, 2016.

###

Unchanged Medical Costs Show Strength of Affordable Care Act's Marketplace

CMS released a [report](#) which shows that per-enrollee medical costs in the ACA individual market were essentially unchanged in 2015, even as costs in the broader insurance market continued to rise. Moreover, the states with the highest enrollment growth saw significant reductions in per-enrollee medical costs. These findings suggest a year-over-year improvement in the ACA individual risk pool, with the Marketplace gaining healthier, lower-cost consumers as it grows.

###

CMS Awards Consumer Assistance Funding To Support 2017 Health Insurance Marketplace Enrollment

With open enrollment for 2017 only a few weeks away, the Centers for Medicare & Medicaid Services (CMS), announced \$63 million in Navigator grant awards to returning and new organizations. These awards will support local in-person assistance to help consumers navigate, shop, and enroll in the wide variety of Marketplace coverage options.

“We are committed to making sure consumers have all the resources they need to find the right plan when open enrollment begins on November 1,” said Kevin Coughlin, CEO of the Health Insurance Marketplace. “We know in-person assistance is critical to connecting individuals and families with quality, affordable health coverage that best meets their needs.”

Navigators are trained individuals and organizations who help consumers, small businesses, and employees as they look for health coverage options and financial assistance through the Marketplace. Navigators can meet in person with consumers and help them understand the coverage options available to them as well as help them pick, apply for, and enroll in a plan of their choice. Consumers in Federally-facilitated Marketplaces, including State Partnership Marketplaces, can visit [Find Local Help](#) to find assistance in their area.

This year, 96 returning organizations and 2 new organizations in the state of Hawaii received a grant award. This is the second year of a three-year funding cycle for the returning grantees that currently provide local in-person assistance. The 2015 Navigator Funding Opportunity Announcement required applicants to submit a proposal covering the full 36-month project period. Funding is released in 12 month increments as CMS continually assesses Navigator grantees' performance for ongoing support.

For a list of CMS Navigator awardees or more information about Navigators and other Marketplace resources, please visit: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Navigator-Grantee-Summaries-2016.pdf>

###

MAKING Health Insurance MAKE SENSE - Answers to Some of the Most Commonly Asked Questions

Q: Isn't it almost time for Medicare Open Enrollment? Is that different from the Open Enrollment Period for the Health Insurance Marketplace? And, if I already have Medicare Part D coverage, do I need to do anything?

A: Medicare Open Enrollment begins on October 15, 2016, and continues until December 7, 2016. That's different from the dates for the Health Insurance Marketplace, which has an Open Enrollment Period starting November 1, 2016, and runs until January 31, 2017.

If you're already enrolled in Medicare and a Medicare Part D plan, and happy with your plan, you don't have to do anything. But there could be big savings for you if you check into the choices you have for next year. That's because plans can, and often do, change from one year to the next. Your needs could change, too. For example, you might be taking new or different medicines now than you were a year ago. If this is the case, it's especially important to look at your choices for 2017 while there's time to change if you want to.

The plan you're enrolled in now will send out information to you about what changes it will make for 2017. You should have received this information by the end of September. By then, the details of other plans available in your area will be posted on the Medicare.gov Plan Finder, so you can compare what you have with what other plans offer. Many people can find a new plan with lower costs, or better coverage of their medications, or sometimes even both. But if you don't go shopping, you may never know that something better is available.

Need help in figuring this all out? Call us, at 1-800-MEDICARE [1-800-633-4227] anytime, 24 hours every day. Or call your local State Health Insurance Assistance Program (SHIP) who can help you with a one-on-one appointment to look at your options. Their number is on the back cover of your Medicare & You handbook. Also, you can get their phone number by calling 1-800-633-4227; just ask for your State Health Insurance Assistance Program or the SHIP in your state.

Q: What about the Health Insurance Marketplace? If I qualify for tax credits to cut the cost of health insurance, could that be a better option for me than my Medicare plan?

A: The Affordable Care Act created the Health Insurance Marketplaces, and provides for tax credits to help reduce the cost of health insurance for many people whose income is less than four times the Federal

Poverty Level – that computes to about \$47,000 per year for a single person, or about \$97,000 per year for a family of four.

However, the Marketplace is not meant to replace Medicare, and if you are already on Medicare, you should not buy a Marketplace health insurance plan. The Medicare plan you have now already includes substantial government help to keep the cost down for you, and you get at least some government help regardless of your income. In addition, Medicare has lower deductibles and lower out of pocket costs than the typical coverage you can get from the Marketplace. Finally, if the seller knows you are Medicare-eligible, it is illegal for them to sell you a private Marketplace plan. There are rare exceptions, but for nearly everyone on Medicare, the best option is to stay on Medicare. The Marketplace also does not sell Medicare Supplemental policies, (also known as Medigap policies), so this is not a place to shop for that coverage.

Need help in figuring this all out? Call us, at 1-800-MEDICARE [1-800-633-4227] anytime, 24 hours every day. Or call your local trained counselors. Their number is on the back cover of your Medicare & You handbook. Also, you can get their phone number by calling 1-800-633-4227; just ask for your State Health Insurance Assistance Program or the SHIP in your state.

Q: During Medicare Open Enrollment periods, especially, fraudulent activity happens more often as Medicare beneficiaries are inundated with communications from organizations vying for their business. What should Medicare beneficiaries know to help protect themselves from being a victim of Medicare fraud?

A: Health care fraud drives up costs for everyone in the health care system.

Fraud schemes often depend on identity thieves getting hold of people's Medicare numbers. So guard your Medicare number. Treat it as you would a credit card.

(Please note that most Medicare Health Plan marketing materials that you receive in the mail are legitimate promotions to educate you on the different Medicare Health Plan options in your area as they are companies who contract with the federal Medicare agency to provide options. However, if a sales representative does any of the following, please know that you can and should report them.)

Follow these important steps to protect yourself from fraud:

- Don't share your Medicare number or other personal information with anyone who contacts you by telephone, email or by approaching you in person, unless you've given them permission in advance. Medicare will NEVER contact you for your Medicare number or other personal information as we have your number.
- Tell your friends and neighbors to guard their Medicare number.
- Don't ever let anyone borrow or pay to use your Medicare number.
- Review your Medicare Summary Notice to be sure you and Medicare are only being charged for actual services that you received.

- Be wary of salespeople who knock on your door or call you uninvited and try to sell you a product or service.
- Don't accept products received through the mail that you didn't order. You should refuse the delivery and/or return it to the sender. Keep a record of the sender's name and the date you returned the items.
- And if you're looking to enroll in a Medicare plan: Be suspicious of anyone who contacts you about Medicare plans unless you gave them permission.
- There are no "early bird discounts" or "limited time offers."
- Don't let anyone rush you to enroll by claiming you need to "act now for the best deal."
- Be skeptical of free gifts, free medical services, discount packages or any offer that sounds "too good to be true."

Any promotional items you're offered to enroll in a plan must be worth no more than \$15, and these items can't be given on the condition that you enroll in a plan.

A common ploy of identity thieves is to say they can send you your free gift right away – they just need your Medicare number to confirm. Decline politely but firmly. Remember, it's not rude to be shrewd!

Call 1-800-MEDICARE [1-800-633-4227] to report suspected fraud. Learn more about protecting yourself from health care fraud by visiting www.Medicare.gov or by contacting your local Senior Medicare Patrol (SMP). To find the SMP in your state, go to the SMP Locator at www.smpresource.org. Or call their Nationwide toll-free number: 1-877-808-2468 and ask for the number in your state.

###

CMS Announces FFM Pilot to Evaluate a Pre-enrollment Verification Process for Special Enrollment Periods

CMS announced plans for a pilot in the Federally-facilitated Marketplace (FFM) to solicit feedback on a pre-enrollment verification process designed to curb potential abuse of special enrollment periods (SEPs). This follows steps previously taken to prevent misuse or abuse of special enrollment periods, such as the [special enrollment confirmation](#) process under which consumers are directed to provide documentation to confirm their eligibility for the special enrollment period after they enroll. The intent in conducting the pre-enrollment verification pilot is to ensure that consumers have access to SEPs while evaluating the impact of pre-enrollment verification of SEP eligibility on compliance, enrollment, continuity of coverage, the risk pool, and other outcomes. While the scope and the design of the pilot are still being determined, CMS intends for the pilot to help inform ongoing SEP verification efforts, including any further policy development within this area.

CMS has posted a [frequently asked questions](#) (FAQ) document with additional details.

###

NEW Marketplace Appeals vs. Coverage Appeals Resource

Consumers who don't agree with a decision by the Marketplace may be able to appeal that decision, and they may also be able to appeal a decision made by their health insurance plan; however, each of those appeals goes through a different process. CMS has released a new resource for assisters to advise consumers on which decisions they can appeal and how to appeal certain decisions depending on who made the decision: the Marketplace or their health insurance plan. You can find the Appeals Chart here: <https://marketplace.cms.gov/technical-assistance-resources/appeal-help.html>

###

Reminder: Federally-facilitated Marketplace Assister Conflict of Interest Requirements

Click [here](#) to access a tip sheet that addresses specific conflict of interest requirements for Navigators, in-person assisters, and certified application counselors (CACs) in Federally-facilitated Marketplaces (FFMs). These conflict of interest requirements are designed to ensure that assisters and assister organizations do not have relationships that could interfere with their ability to provide unbiased outreach and enrollment assistance to consumers. Specifically, certain relationships with health insurance issuers or stop-loss insurance issuers could affect, or appear to affect, the impartiality of the help these assisters provide to consumers. Staying free from these conflicts of interest helps assisters satisfy their duty to provide fair, accurate, and impartial information and avoid steering a consumer toward a certain plan. Click [here](#) to access the tip sheet and click [here](#) to review the Marketplace Assister presentation that discussed this topic on September 16th.

###

Reminder: CMS Proposes New Standards to Strengthen the Marketplace for 2018

The Centers for Medicare & Medicaid Services (CMS) has issued the proposed annual Notice of Benefit and Payment Parameters for 2018, which proposes additional steps to strengthen the Health Insurance Marketplace. CMS is issuing this rule earlier in the calendar year in order to provide more certainty to the Marketplace as it continues to mature.

- [CMS Press Release](#)
- [CMS Fact Sheet](#)
- [Proposed 2018 Payment Notice](#) (CMS-9934-P) and on 09/06/2016 available online [here](#).

We encourage you to comment on the proposed rule. Comments are due on October 6, 2016.

###

CCIIO Sub-Regulatory Guidance: Issuer Posting Of Rate Filing Information

The Centers for Medicare & Medicaid Services (CMS) released a bulletin clarifying the regulatory requirements imposed on health insurance issuers who implement rate increases that are determined to be unreasonable by CMS or a state with an effective rate review program. Specifically, the bulletin explains the manner in which an issuer must “prominently post” its Final Justification for implementing an unreasonable rate increase and clarifies the type of information that must be included in the Final Justification. The bulletin further clarifies that an issuer must prominently display the Final Justification for at least three years.

For more information, click here: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Prominent-display-bulletin-final.pdf>

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Medicare and Medicaid Updates

Social Security Number Removal Initiative (SSNRI) Updated Landing page

The Centers for Medicare & Medicaid Services (CMS) updated the web landing pages and messaging to key stakeholders as part of its efforts to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019 as required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

These updates offer health care providers, industry and others information on a new Medicare Beneficiary Identifier (MBI) that will replace the SSN-based information on the new Medicare cards for Medicare transactions, like billing, eligibility status, and claim status.

For additional information on the Social Security Number Removal Initiative (SSNRI) home page click here: <https://www.cms.gov/Medicare/SSNRI/Index.html>

Other helpful links:

- SSNRI MBI format link: <https://www.cms.gov/Medicare/SSNRI/MBI-Format-PDF.PDF>
- SSNRI Health & Drug Plans: <https://www.cms.gov/Medicare/SSNRI/Health-and-Drug-Plans/Health-and-drug-plans.html>
- SSNRI Providers: <https://www.cms.gov/Medicare/SSNRI/Providers/Providers.html>
- SSNRI States: <https://www.cms.gov/Medicare/SSNRI/States/States.html>
- SSNRI Partners /Employers: <https://www.cms.gov/Medicare/SSNRI/Partners-and-Employers/Partners-and-employers.html>

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Medicare Learning Network News

News & Announcements

- [Revised CMS-855R Application Available: Reassignment of Medicare Benefits](#)
- [IRF and LTCH QRP Provider Preview Reports – Review Your Data by September 30](#)
- [eCOI Resource Center has News and Resources](#)
- [EHR Incentive Program 2017 Medicare Payment Adjustment for Hospitals](#)
- [IRF and LTCH QRP Provider Preview Reports Available until September 30](#)
- [DMEPOS Suppliers: Use Revised CMS-855S Beginning January 1](#)
- [DMEPOS Fee Schedule: Corrections to the July 2016 File](#)
- [DMEPOS Fee Schedule: Assignment Monitoring Data Posted](#)
- [SNF 30-Day Potentially Preventable Readmission Measure — Updated](#)
- [2015 PQRS Feedback Reports and 2015 Annual QRURs: Are You Ready?](#)
- [New Look for Think Cultural Health](#)
- [Healthy Aging® Month — Discuss Preventive Services with your Patients](#)

Provider Compliance

- [Reporting Changes in Ownership](#)
- [Coudé Tip Catheters](#)

Claims, Pricers & Codes

- [October 2016 Average Sales Price Files Now Available](#)

Upcoming Events

- [Emergency Preparedness Requirements Call — October 5](#)
- [Comparative Billing Report on Modifier 25: OB/GYN Webinar — October 5](#)
- [IMPACT Act: Data Elements and Measure Development Call — October 13](#)
- [Comparative Billing Report on CMT of the Spine Webinar – October 19](#)

Medicare Learning Network® Publications & Multimedia

- [Fee-For-Service Data Collection System: CLFS Data Reporting Template MLN Matters® Article — Revised](#)
- [Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training — Revised](#)

- [Transitional Care Management Services Fact Sheet — Revised](#)
- [Federally Qualified Health Center Fact Sheet – Revised](#)
- [Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised](#)
- [Hospital Outpatient Prospective Payment System Fact Sheet — Revised](#)
- [Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Fact Sheet — Revised](#)
- [Medicare Ambulance Transports Booklet — Revised](#)
- [Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised](#)
- [Critical Access Hospital Booklet — Revised](#)
- [Advance Care Planning Fact Sheet — New](#)

###

Competitive Bidding Program Continues To Maintain Access and Quality While Helping To Save Medicare Millions

Overview

The Centers for Medicare & Medicaid Services (CMS) announced the new single payment amounts and began sending contract offers to successful bidders for Medicare’s Round 1 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. These new payment amounts and contracts go into effect on January 1, 2017. This program has been an essential tool to help Medicare set appropriate payment rates for DMEPOS items and save money for beneficiaries and taxpayers while ensuring access to quality items.

Prior to the DMEPOS Competitive Bidding Program, Medicare paid for these DMEPOS items using a fee schedule that is generally based on historic supplier charges from the 1980s. Numerous studies from the Department of Health and Human Services Office of Inspector General and the Government Accountability Office have shown these fee schedule prices to be excessive, and taxpayers and Medicare beneficiaries bear the burden of these excessive payments.

Under the Competitive Bidding Program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. Since implementation of the DMEPOS Competitive Bidding Program on January 1, 2011, CMS has saved approximately \$220 million per year in the nine Round 1 metropolitan statistical areas (MSAs) due to competitive bidding and other CMS fraud, waste, and abuse initiatives. Health monitoring data indicate that the program implementation is going smoothly with few inquiries or complaints and no negative beneficiary health outcomes.

The Round 1 Recompete contract period expires on December 31, 2016. Round 1 2017 contracts will become effective on January 1, 2017 through December 31, 2018.

Background

The Medicare DMEPOS Competitive Bidding Program was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“Medicare Modernization Act” or “MMA”) after the conclusion of successful demonstration projects. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 MSAs in 2007.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS successfully conducted the supplier competition again in nine areas in 2009, referring to it as the Round 1 Rebid.

MIPPA also delayed the competition for Round 2 from 2009 to 2011 and authorized national mail-order competitions after 2010. The Affordable Care Act of 2010 (ACA) expanded the number of Round 2 MSAs from 70 to 91 and specified that all areas of the country be subject to either DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by January 1, 2016.

Competitive bidding contracts and pricing have been in place in Round 1 areas since January 1, 2011, and since July 1, 2013, in Round 2 areas. The national mail-order program for diabetes testing supplies was first implemented on July 1, 2013, with recompeted contracts and pricing being in place since July 1, 2016. Like Round 1 2017, Round 2 Recompete and the national mail-order recompete contracts will expire on December 31, 2018, at which point CMS will be implementing a consolidated round of competition to include all Round 1, Round 2, and national mail order competitive bidding areas.

Contract Award Process

The DMEPOS Competitive Bidding Program's bid evaluation process ensures that there will be a sufficient number of suppliers to meet the needs of the beneficiaries living in a competitive bidding area. The new single payment amounts resulting from the competition replace the previous single payment amounts for the bid items in these areas. Small suppliers, those with gross revenues of \$3.5 million or less, make up about 46 percent of the suppliers that will be offered contracts for Round 1 2017. All suppliers that are offered contracts went through a thorough vetting process and are accredited and meet financial and applicable licensing standards.

CMS will now begin offering contracts to winning bidders. 1,523 contract offers will be made to 198 Round 1 2017 bidders. Of these offers, 97 percent are to bidders who currently furnish items in the awarded area or within the product category. The winning suppliers have 603 locations to serve Medicare beneficiaries in the competitive bidding areas. CMS expects to complete the contracting process in time to announce the contract suppliers in the fall of 2016. Bidders that are not offered contracts will be notified of the reasons why they did not qualify for the program when the contracting process is complete. Suppliers that are not contract suppliers for this round of the DMEPOS Competitive Bidding Program may bid in future rounds, unless they are precluded from participation in the program.

Additional information on the distribution of contract offers is available at the following Web site: www.dmecompetitivebid.com.

Real-Time Monitoring

Importantly, the program has maintained beneficiary access to quality products from accredited suppliers in all competitive bidding areas. Extensive real-time monitoring data have shown successful implementation with very few beneficiary complaints and no negative impact on beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency room visits compared to non-competitive bidding areas. In addition to our real-time claims monitoring, CMS also requested

feedback from beneficiaries through consumer satisfaction surveys conducted before and after the rollout of the program. CMS provides local, on-the-ground presence in each competitive bidding area through the CMS regional offices, local liaisons, and a Competitive Acquisition Ombudsman who closely monitors and responds to inquiries and complaints about the application of the program from beneficiaries who use items of DMEPOS under the program, contract suppliers who provide these items, and other stakeholders. There is also a formal complaint process for beneficiaries, caregivers, providers and suppliers to use for reporting concerns about contract suppliers or other competitive bidding implementation issues. In addition, contract suppliers are responsible for submitting reports identifying the brands of products they furnish, which is used to inform beneficiaries, caregivers, and referral agents. CMS will continue to employ the same aggressive program monitoring for future rounds.

Round 1 2017 Product Categories and Areas

The Round 1 2017 product categories are:

- Enteral Nutrients, Equipment, and Supplies
- General Home Equipment and Related Supplies and Accessories
 - includes hospital beds and related accessories, group 1 and 2 support surfaces, commode chairs, patient lifts, and seat lifts
- Nebulizers and Related Supplies
- Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories
- Respiratory Equipment and Related Supplies and Accessories
 - includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Standard Mobility Equipment and Related Accessories
 - includes walkers, standard power and manual wheelchairs, scooters, and related accessories
- Transcutaneous Electrical Nerve Stimulation (TENS) Devices and Supplies

For a list of the specific items in each product category, or for a list of the areas included in Round 1 2017, visit the Competitive Bidding Implementation Contractor website at www.dmecompetitivebid.com.

Round 1 2017 Timeline of Events

- | | |
|--------------------------|---|
| September 8, 2016 | CMS announces new payment rates for Round 1 2017 and begins contracting process with winning suppliers |
| Fall 2016 | CMS announces the Medicare contract suppliers for Round 1 2017; intensifies supplier, referral agent, and beneficiary education program |
| January 1, 2017 | Implementation of Medicare DMEPOS Competitive Bidding Program Round 1 2017 contracts and prices |

Additional Information

For additional information about the Medicare DMEPOS Competitive Bidding Program, please visit: <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/>.

###

Visit the [CMS Events Page to Review Program Requirements for EPs and Eligible Hospitals/CAHs](#)

The Centers for Medicare & Medicaid Services (CMS) has posted the presentations and webinar recordings from the recent 2016 EHR Incentive Programs Requirements webinars for eligible professionals (EPs), and eligible hospitals and critical access hospitals (CAHs) on the [CMS EHR Events page](#). CMS hosted these events to explain the requirements providers must meet to successfully participate in the EHR Incentive Programs in 2016, based on the October 2015 [final rule](#). CMS plans to host additional webinars for the public to learn more about program requirements. Registration details will be announced as soon as they are available.

For More Information

To learn more, review the *What You Need to Know in 2016 Tip Sheets for [Eligible Professionals](#) and [Eligible Hospitals/CAHs](#)*, and other resources on the [2016 Program Requirements](#) page of the [CMS EHR Incentive Programs website](#).

###

[CMS Finalizes Rule to Bolster Emergency Preparedness of Certain Facilities Participating In Medicare and Medicaid](#)

The Centers for Medicare & Medicaid Services (CMS) [finalized a rule](#) to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and man-made disasters.

Over the past several years, and most recently in Louisiana, a number of natural and man-made disasters have put the health and safety of Medicare and Medicaid beneficiaries – and the public at large – at risk. These new requirements will require certain participating providers and suppliers to plan for disasters and coordinate with federal, state tribal, regional, and local emergency preparedness systems to ensure that facilities are adequately prepared to meet the needs of their patients during disasters and emergency situations.

“Situations like the recent flooding in Baton Rouge, Louisiana, remind us that in the event of an emergency, the first priority of health care providers and suppliers is to protect the health and safety of their patients,” said CMS Deputy Administrator and Chief Medical Officer Patrick Conway, M.D., MSc. “Preparation, planning, and one comprehensive approach for emergency preparedness is key. One life lost is one too many.”

“As people with medical needs are cared for in increasingly diverse settings, disaster preparedness is not only a responsibility of hospitals, but of many other providers and suppliers of healthcare services. Whether it’s trauma care or long-term nursing care or a home health service, patients’ needs for health care don’t

stop when disasters strike; in fact their needs often increase in the immediate aftermath of a disaster,” said Dr. Nicole Lurie, HHS assistant secretary for preparedness and response. “All parts of the healthcare system must be able to keep providing care through a disaster, both to save lives and to ensure that people can continue to function in their usual setting. Disasters tend to stress the entire health care system, and that’s not good for anyone.”

After reviewing the current Medicare emergency preparedness regulations for both providers and suppliers, CMS found that regulatory requirements were not comprehensive enough to address the complexities of emergency preparedness. For example, the requirements did not address the need for: (1) communication to coordinate with other systems of care within cities or states; (2) contingency planning; and (3) training of personnel. CMS proposed policies to address these gaps in the proposed rule, which was open to stakeholder comments.

After careful consideration of stakeholder comments on the proposed rule, this final rule requires Medicare and Medicaid participating providers and suppliers to meet the following four common and well known industry best practice standards.

1. **Emergency plan:** Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the location of a provider or supplier.
2. **Policies and procedures:** Develop and implement policies and procedures based on the plan and risk assessment.
3. **Communication plan:** Develop and maintain a communication plan that complies with both Federal and State law. Patient care must be well-coordinated within the facility, across health care providers, and with State and local public health departments and emergency systems.
4. **Training and testing program:** Develop and maintain training and testing programs, including initial and annual trainings, and conduct drills and exercises or participate in an actual incident that tests the plan.

These standards are adjusted to reflect the characteristics of each type of provider and supplier. For example:

- Outpatient providers and suppliers such as Ambulatory Surgical Centers and End-Stage Renal Disease Facilities will not be required to have policies and procedures for provision of subsistence needs.
- Hospitals, Critical Access Hospitals, and Long Term Care facilities will be required to install and maintain emergency and standby power systems based on their emergency plan.

In response to comments, CMS made changes in several areas of the final rule, including removing the requirement for additional hours of generator testing, flexibility to choose the type of exercise a facility conducts for its second annual testing requirement, and allowing a separately certified facility within a healthcare system to take part in the system’s unified emergency preparedness program.

The final rule also includes a number of local and national resources related to emergency preparedness, including helpful reports, toolkits, and samples. Additionally, health care providers and suppliers can

choose to participate in their local healthcare coalitions, which provide an opportunity to share resources and expertise in developing an emergency plan and also can provide support during an emergency.

These regulations are effective 60 days after publication in the Federal Register. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date.

For more information please see a [blog](#) by Dr. Lurie, HHS assistant secretary for preparedness and response, and the CMS [Survey & Certification – Emergency Preparedness](#) webpage.

###

“Plans for the Quality Payment Program in 2017: Pick Your Pace”

As the baby boom generation ages, 10,000 people enter the Medicare program each day. Facing that demand, it is essential that Medicare continues to support physicians in delivering high-quality patient care. This includes increasing its focus on patient outcomes and reducing the obstacles that make it harder for physicians to practice good care.

The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) offers the opportunity to advance these goals and put Medicare on surer footing. Among other policies, it repeals the Sustainable Growth Rate formula and its annual payment cliffs, streamlines the existing patchwork of Medicare reporting programs, and provides opportunities for physicians and other clinicians to earn more by focusing on quality patient care. We are referring to these provisions of MACRA collectively as the Quality Payment Program.

We received feedback on [our April proposal](#) for implementing the Quality Payment Program, both in writing and as we talked to thousands of physicians and other clinicians across the country. Universally, the clinician community wants a system that begins and ends with what's right for the patient. We heard from physicians and other clinicians on how technology can help with patient care and how excessive reporting can distract from patient care; how new programs like medical homes can be encouraged; and the unique issues facing small and rural non-hospital-based physicians. We will address these areas and the many other comments we received when we release the final rule by November 1, 2016.

But, with the Quality Payment Program set to begin on January 1, 2017, we wanted to share our plans for the timing of reporting for the first year of the program. In recognition of the wide diversity of physician practices, we intend for the Quality Payment Program to allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017. During 2017, eligible physicians and other clinicians will have multiple options for participation. Choosing one of these options would ensure you do not receive a negative payment adjustment in 2019. These options and other supporting details will be described fully in the final rule.

First Option: Test the Quality Payment Program.

With this option, as long as you submit some data to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment. This first option is designed to ensure that your system is working and that you are prepared for broader participation in 2018 and 2019 as you learn more.

Second Option: Participate for part of the calendar year.

You may choose to submit Quality Payment Program information for a reduced number of days. This means your first performance period could begin later than January 1, 2017 and your practice could still qualify for a small positive payment adjustment. For example, if you submit information for part of the

calendar year for quality measures, how your practice uses technology, and what improvement activities your practice is undertaking, you could qualify for a small positive payment adjustment. You could select from the list of quality measures and improvement activities available under the Quality Payment Program.

Third Option: Participate for the full calendar year.

For practices that are ready to go on January 1, 2017, you may choose to submit Quality Payment Program information for a full calendar year. This means your first performance period would begin on January 1, 2017. For example, if you submit information for the entire year on quality measures, how your practice uses technology, and what improvement activities your practice is undertaking, you could qualify for a modest positive payment adjustment. We've seen physician practices of all sizes successfully submit a full year's quality data, and expect many will be ready to do so.

Fourth Option: Participate in an Advanced Alternative Payment Model in 2017.

Instead of reporting quality data and other information, the law allows you to participate in the Quality Payment Program by joining an Advanced Alternative Payment Model, such as Medicare Shared Savings Track 2 or 3 in 2017. If you receive enough of your Medicare payments or see enough of your Medicare patients through the Advanced Alternative Payment Model in 2017, then you would qualify for a 5 percent incentive payment in 2019.

However, you choose to participate in 2017, we will have resources available to assist you and walk you through what needs to be done. And however you choose to participate, your feedback will be invaluable to building this program for the long term to achieve outcomes that matter to your patients.

We appreciate the sincere and constructive participation in the feedback process to date and look forward to advancing step-by-step in that same spirit. We look forward to releasing the final details about the program this fall. Most importantly, we look forward to further engagement with physicians and other clinicians toward our shared goal of the highest quality of care and best outcomes for patients.

Helpful Links

Quality Payment Program: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html>

Quality Payment Program: Delivery System Reform, Medicare Payment Reform, & MACRA: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

###

Medicare Advantage premiums remain stable in 2017; beneficiaries have saved over \$23.5 billion on prescription drugs

The Affordable Care Act has made the Medicare program stronger for seniors and people with disabilities

The Centers for Medicare & Medicaid Services (CMS) announced that 2017 Medicare Advantage premiums will remain stable and more enrollees will have access to higher quality plans while, for the seventh straight year, enrollment is projected to increase to a new all-time high. In addition, CMS released updated information that shows that millions of seniors and people with disabilities with Medicare continue to enjoy prescription drug discounts and affordable benefits as a result of the Affordable Care Act. The announcement comes as CMS releases the premiums and costs for Medicare health and drug plans for the 2017 calendar year.

CMS estimates that the average Medicare Advantage monthly premium will decrease by \$1.19 (about 4 percent) in 2017, from \$32.59 on average in 2016 to \$31.40. This would be 13 percent lower than the average Medicare Advantage premium prior to passage of the Affordable Care Act. The majority of Medicare Advantage enrollees (67 percent) will experience no premium increase.

“Medicare Advantage and the prescription drug benefit continue to be a great option for seniors and people living with disabilities,” said Andy Slavitt, CMS Acting Administrator. “Medicare enrollees will continue to have access to predictable premiums and high quality care.”

Access to the Medicare Advantage program will remain strong, with 99 percent of Medicare beneficiaries having access to a Medicare health plan. In addition, in 2017, more Medicare Advantage plans will offer more supplemental benefits for enrollees, such as dental, vision, and hearing benefits.

Enrollment is projected to increase to 18.5 million enrollees next year, a 60 percent increase from 2010. In 2017, 32 percent of all Medicare enrollees will be in a Medicare Advantage plan compared to only 24 percent in 2010.

Average premiums in the Medicare Part D prescription drug program will also remain stable and beneficiaries have saved billions on prescription drugs. In July 2016, CMS announced that the average basic premium for a Medicare prescription drug plan in 2017 is projected to be an estimated \$34 per month. The projections show that access to a prescription drug plan will remain strong in 2017, with 100 percent access to a plan in the individual market and improved access to employer plans.

Because of the Affordable Care Act, people with Medicare are seeing reduced costs through both savings on covered brand-name and generic drugs and access to certain preventive services with no cost sharing. Since the enactment of the Affordable Care Act through July 2016, more than 11 million seniors and people with disabilities have received savings and discounts in the coverage gap of over \$23.5 billion on prescription drugs, an average of \$2,127 per beneficiary thanks to the law.

Medicare Open Enrollment for 2017 Medicare health and drug plans begins on October 15, 2016 and ends on December 7, 2016. Plan costs and covered benefits can change from year to year. Medicare beneficiaries should look at their coverage choices and decide what options best meet their needs. Beneficiaries can visit [Medicare.gov](http://www.medicare.gov) (<http://www.medicare.gov>), call 1-800-MEDICARE, or contact their State Health Insurance Assistance Program (SHIP). Beneficiaries who are satisfied with their current coverage do not need to do anything.

For more information on the premiums and costs of 2017 Medicare health and drug plans, please visit: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html>

For a fact sheet on Medicare Advantage and Part D, please visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-09-22.html>

For more information on Medicare Open Enrollment, including state-by-state fact sheets, please visit: <https://www.cms.gov/Outreach-and-Education/Reach-Out/Find-tools-to-help-you-help-others/Open-Enrollment-Outreach-and-Media-Materials.html>

For state-by-state information on discounts in the donut hole, please visit:

<https://downloads.cms.gov/files/Medicare%20Part%20D%20donut%20hole%20by%20state%20YTD2016%20through%20July%202016.pdf>

For state-by-state information on utilization of preventive services at no cost sharing to beneficiaries in Medicare, please visit:

https://downloads.cms.gov/files/Medicare_Beneficiaries_Utilizing_Free_Preventive_Services_by_State_YTD2016.pdf

###

2017 Reassignment of Low-Income Subsidy Beneficiaries in Non-Renewing Medicare Advantage Plans and Medicare Advantage Plans Reducing their Service Areas

Overview of the Medicare Advantage Reassignment Process

In October, the Centers for Medicare & Medicaid Services (CMS) will conduct reassignment of beneficiaries eligible for the Part D low-income subsidy (LIS) who are enrolled in certain Medicare Advantage (MA) plans as described below. CMS will carry out all reassignments, including assigning beneficiaries into zero premium prescription drug plans (PDPs) owned by the same organization, if available, or randomly assigning beneficiaries to PDPs offered by different sponsors.

CMS will reassign only individuals who meet the following criteria:

1. Are LIS-eligible in 2016 and will remain LIS-eligible in 2017; and
2. Are enrolled in an MA plan that will be non-renewing or has a service area reduction (SAR), unless the plan is an MA Private Fee-for-Service plan and the individual already has concomitant enrollment in a stand-alone PDP that is not affected by PDP premium increase reassignment for 2017.

For further guidance on this process, please see §40.1.8 of Chapter 2 (Enrollment and Disenrollment) of the Medicare Managed Care Manual (“Chapter 2”), available at <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html>

Please note that reassignment occurs for MA plans that are non-renewing or have an approved SAR as of 2017, including non-renewing MA-only plans as well as Medicare Advantage Prescription Drug (MA PD) plans. Beneficiaries in these MA plans are reassigned into PDPs only, but they will have the option of electing another MA plan. Information about reassignment of beneficiaries enrolled in PDPs is provided in separate guidance (please refer to the memorandum “*2017 Reassignment of Low-Income Subsidy Beneficiaries in Prescription Drug Plans*” dated September 19, 2016, from Michael Crochunis, Acting Director, Medicare Enrollment & Appeals Group, available in HPMS). In addition, LIS-eligible beneficiaries in U.S. territories or employer-sponsored MA-only or MA PD plans will not be reassigned.

Key information about this year’s process is outlined below, including details about the beneficiary notifications sent by CMS and a reassignment process timeline.

CMS Notification to Affected Beneficiaries

CMS plans to mail notices (printed on blue paper) to the affected beneficiaries in late October. These notices will inform beneficiaries who are being reassigned of their prospective zero premium PDP and indicate that they will have Original Medicare as their health coverage unless they choose another MA plan.

As required by the Affordable Care Act of 2010, CMS will mail a second blue letter to these beneficiaries in December. This second notice will identify which drugs in their current drug regimen are on the formulary of the 2017 plan to which they are being reassigned, and how to request an exception or appeal, or file a grievance. Once these notices are finalized in September, they will be available at: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/LIS-Notices-and-Mailings.html>

CMS Notification to Gaining PDPs

CMS also notifies PDPs of individuals who will be reassigned to their plan for 2017 from non-renewing MA plans. For requirements applicable to gaining PDPs, please refer to the memorandum “*2017 Reassignment of Low-Income Subsidy Beneficiaries in Prescription Drug Plans*” dated September 19, 2016, from Michael Crochunis, Acting Director, Medicare Enrollment & Appeals Group, available in HPMS.

Plan Non-Renewal Communication to Affected Beneficiaries

Please refer to the memorandum “*Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models*” dated September 21, 2016, from Kathryn A. Coleman, Director, Medicare Drug & Health Plan Contract Administration Group for guidance on non-renewal specifics about how beneficiaries must be notified about the non-renewal. For more information on requirements related to non-renewal generally, please refer to the “*Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*” dated April 4, 2016, which can be found at: <http://www.cms.gov/Medicare/HealthPlans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>.

End-of-Year Timeline for Reassignment

Please be sure to adhere to the all deadlines.

October 02, 2016 – Beneficiaries that are in MA plans that are non-renewing (or have an approved SAR) for CY 2017 must receive the beneficiary specific non-renewal notices from the non-renewing MA organization.

October 03, 2016 – MA organizations with approved renewal/non-renewal scenarios that require the plan to submit enrollment and/or disenrollment transactions, such as certain SAR scenario, must submit those transactions following the requirements in the annual End of Year processing guidance memorandum (to be provided shortly).

October 10, 2016 – The special TRR showing successfully processed reassignments estimated to be available (see additional detail on page 2).

Mid-October, 2016 – CMS anticipates providing lists of PDP and MA reassignees to States, 1-800-MEDICARE, and losing and gaining PDPs.

Late October, 2016 – CMS begins mailing beneficiary reassignment notices on blue paper.

Mid-December, 2016 – CMS begins mailing reassigned beneficiaries a second blue notice identifying which drugs in their current drug regimen are on the formulary of the 2017 plan to which they are being reassigned, and how to request an exception or appeal, or file a grievance.

January 1, 2017 – Reassignment effective date.

For Assistance

If you have specific policy questions about any of these instructions, please contact Steve Ludwig at 410-786-0554 or Stephen.Ludwig@cms.hhs.gov. If you have technical questions about file format or transactions, you should contact the MAPD Help Desk at 1-800-927-8069 or MAPDhelp@cms.hhs.gov.

###

*New Data: 49 States Plus DC Reduce Avoidable Hospital Readmissions
Affordable Care Act reforms helping Medicare beneficiaries experience better care at lower cost*

The unfortunate experience of having to return to the hospital after recently being treated—or watching the same thing happen to a friend or family member—is all too common. Potentially avoidable hospital readmissions that occur within 30 days of a patient’s initial discharge are estimated to account for more than \$17 billion in Medicare expenditures annually.^[1] Not only are readmissions costly, but they are often a sign of poor quality care. Many readmissions can be avoided through improvements in care, such as making sure that patients leave the hospital with appropriate medications, instructions for follow-up care, and follow-up appointments scheduled to make sure their recovery stays on track.

To address the problem of avoidable readmissions, the Affordable Care Act created the [Hospital Readmissions Reduction Program](#), which adjusts payments for hospitals with higher than expected 30-day readmission rates for targeted clinical conditions such as heart attacks, heart failure, and pneumonia. The Centers for Medicare & Medicaid Services has also undertaken other major quality improvement initiatives, such as the [Partnership for Patients](#), which aim to make hospital care safer and improve the quality of care for individuals as they move from one health care setting to another.

The data show that these efforts are working. As described below, between 2010 and 2015, readmission rates fell by 8 percent nationally. CMS released new data showing how these improvements are helping Medicare patients across all 50 states and the District of Columbia. The data show that since 2010:

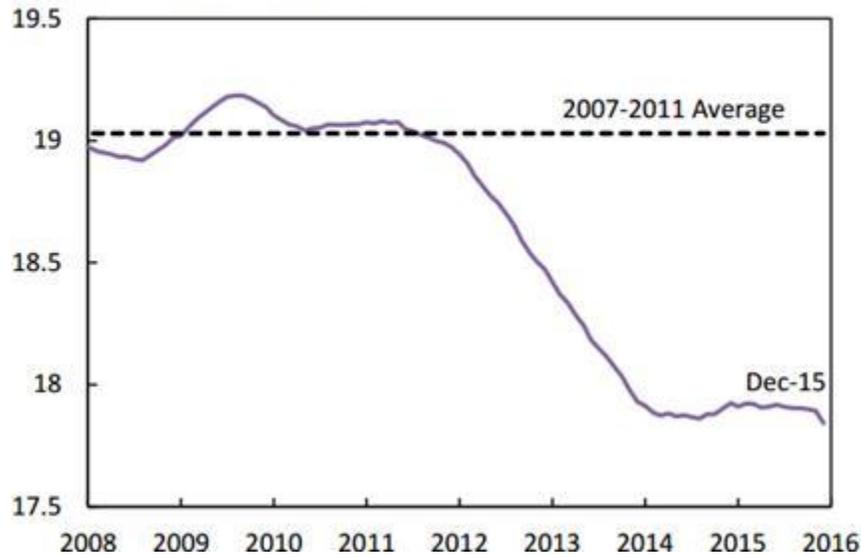
- All states but one have seen Medicare 30-day readmission rates fall.^[2]
- In 43 states, readmission rates fell by more than 5 percent.
- In 11 states, readmission rates fell by more than 10 percent.

^[1] Jencks, S. F., Williams, M. V. and Coleman, E. A. (2009). 'Rehospitalizations among patients in the Medicare fee-for-service program'. *New England Journal of Medicine*, 360 (14), 1418-1428.

^[2] The readmission rate in Vermont was virtually unchanged, increasing slightly from 15.3% in 2010 to 15.4% in 2015. This change correlates to 21 additional readmissions compared to if the state’s rate had remained constant.

Medicare 30-Day, All-Condition Hospital Readmission Rate

Percent, 12-month moving average



Across states, Medicare beneficiaries avoided approximately 100,000 readmissions in 2015 alone, compared to if readmission rates had stayed constant at 2010 levels. That means Medicare beneficiaries collectively avoided nearly 100,000 unnecessary return trips to the hospital. Cumulatively since 2010, the HHS Assistant Secretary for Planning and Evaluation [estimates](#) that Medicare beneficiaries have avoided 565,000 readmissions.

The Hospital Readmissions Reduction Program is just one part of the Administration’s broader strategy to reform the health care system by paying providers for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality. Other initiatives include Accountable Care Organizations, as well as efforts by Quality Improvement Organizations and Hospital Engagement Networks, which fund quality improvement expert consultants to work with provider and hospital communities to improve care. The goal of all of these efforts is to spend our health care dollars more wisely to promote better care for Medicare beneficiaries and other Americans across the country.

State	2010		2015		% Change in Readmission Rates	Reduction in readmissions in 2015 compared to 2010
	Hospital Admissions	Readmission Rate	Hospital Admissions	Readmission Rate		
AK	9,809	14.50%	9,954	13.70%	-5.50%	-78
AL	154,856	17.20%	143,210	16.20%	-5.80%	-1,503
AR	103,056	17.70%	92,562	16.60%	-6.20%	-993

AZ	135,293	16.60%	128,061	14.80%	-10.80%	-2,270
CA	574,176	17.60%	547,558	16.60%	-5.70%	-5,580
CO	83,346	14.20%	81,822	12.90%	-9.20%	-1,099
CT	109,888	18.10%	96,492	16.70%	-7.70%	-1,306
DC	23,907	20.00%	23,194	18.50%	-7.50%	-346
DE	29,827	17.40%	32,257	15.60%	-10.30%	-575
FL	619,368	18.20%	588,187	17.70%	-2.70%	-3,161
GA	209,500	17.50%	191,485	16.20%	-7.40%	-2,453
HI	16,824	14.90%	15,799	12.90%	-13.40%	-315
IA	100,490	15.50%	91,256	14.50%	-6.50%	-910
ID	25,432	12.50%	28,139	12.20%	-2.40%	-78
IL	421,395	19.80%	335,610	17.40%	-12.10%	-8,108
IN	210,919	17.40%	186,241	16.10%	-7.50%	-2,474
KS	90,545	16.30%	87,224	14.70%	-9.80%	-1,361
KY	162,249	19.70%	132,511	17.90%	-9.10%	-2,384
LA	129,123	18.70%	112,328	16.90%	-9.60%	-2,013
MA	208,356	19.00%	197,649	17.90%	-5.80%	-2,213
MD	189,323	21.10%	170,510	18.90%	-10.40%	-3,789
ME	43,450	16.10%	38,571	15.50%	-3.70%	-232
MI	343,346	18.60%	280,152	18.00%	-3.20%	-1,767
MN	129,642	15.70%	130,725	14.60%	-7.00%	-1,435
MO	203,685	18.20%	174,677	16.90%	-7.10%	-2,311
MS	106,281	19.10%	96,252	17.60%	-7.90%	-1,469
MT	27,962	13.90%	27,518	13.10%	-5.80%	-231
NC	269,108	17.00%	235,283	15.90%	-6.50%	-2,472
ND	26,562	15.40%	26,650	14.40%	-6.50%	-267
NE	60,007	15.70%	56,791	14.40%	-8.30%	-735

NH	36,189	15.70%	39,871	15.30%	-2.50%	-152
NJ	281,282	20.30%	250,924	17.60%	-13.30%	-6,774
NM	36,209	15.20%	33,016	14.80%	-2.60%	-118
NV	51,787	18.00%	52,308	17.00%	-5.60%	-529
NY	491,897	19.90%	402,439	17.80%	-10.60%	-8,407
OH	325,091	18.80%	267,743	16.80%	-10.60%	-5,405
OK	119,346	17.40%	106,073	15.60%	-10.30%	-1,878
OR	58,182	14.30%	61,393	14.20%	-0.70%	-75
PA	369,418	18.10%	324,166	16.60%	-8.30%	-4,995
RI	24,142	19.00%	24,705	17.00%	-10.50%	-487
SC	130,950	16.50%	125,993	15.50%	-6.10%	-1,237
SD	31,269	14.90%	30,806	13.20%	-11.40%	-515
TN	207,875	18.40%	180,666	16.80%	-8.70%	-2,905
TX	571,147	17.10%	509,738	16.10%	-5.80%	-4,960
UT	33,534	12.20%	38,142	11.50%	-5.70%	-261
VA	207,241	17.50%	211,674	16.40%	-6.30%	-2,302
VT	15,439	15.30%	16,332	15.40%	0.70%	21
WA	130,798	15.30%	131,817	14.20%	-7.20%	-1,388
WI	137,336	15.60%	124,274	14.50%	-7.10%	-1,373
WV	70,144	19.90%	60,630	18.60%	-6.50%	-777
WY	13,277	15.10%	12,838	14.20%	-6.00%	-110

###

Guide to consumer mailings from CMS, Social Security, & plans in 2016/2017

<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/2016-2017-Mailings.pdf>

###

Physicians and Health Care Providers Continue To Improve Quality of Care, Lower Costs
Affordable Care Act Accountable Care Organization initiatives put patients at the center of their care while
generating more than \$1.29 billion in total Medicare savings since 2012

The Centers for Medicare & Medicaid Services (CMS) announced the 2015 performance year results for the Medicare Shared Savings Program and the Pioneer Accountable Care Organization Model that show physicians, hospitals, and health care providers participating in Accountable Care Organizations continue to make significant improvements in the quality of care for Medicare beneficiaries, while achieving cost savings. Collectively, Medicare Accountable Care Organizations have generated more than \$1.29 billion in total Medicare savings since 2012.

“The coordinated, physician-led care provided by Accountable Care Organizations resulted in better care for over 7.7 million Medicare beneficiaries while also reducing costs,” said CMS Acting Administrator Andy Slavitt. “I congratulate these leaders and look forward to significant growth in the program in the coming year.”

In 2015, Medicare Accountable Care Organizations had combined total program savings of \$466 million, which includes all Accountable Care Organizations’ experiences, for 392 Medicare Shared Savings Program participants and 12 Pioneer Accountable Care Organization Model participants. The results show that more Accountable Care Organizations shared savings in 2015 compared to 2014 and those with more experience tend to perform better over time.

Results from the Medicare Shared Savings Program and the Pioneer Accountable Care Organization Model show significant improvements in the quality of care providers are offering to an increasing number of Medicare beneficiaries. Accountable Care Organizations are judged on their performance, as well as their improvement, on an array of meaningful metrics that assess the care they deliver. Those metrics include how highly patients rated their doctor, how well clinicians communicated, whether patients are screened for high blood pressure, and their use of Electronic Health Records.

All 12 participants in the Pioneer Accountable Care Organization Model improved their quality scores from 2012 to 2015 by more than 21 percentage points. Overall quality scores for nine out of 12 Pioneer participants were more than 90 percent in 2015.

Accountable Care Organizations in the Medicare Shared Savings Program also continued to show improvement, with Accountable Care Organizations that reported in both 2014 and 2015 improving on 84 percent of the quality measures that were reported in both years. Additionally, comparing 2014 and 2015 results, average quality performance improved by more than 15 percent on key preventive care measures including screening for risk of future falls, depression screening and follow-up, blood pressure screening and follow-up, and providing pneumonia vaccinations.

By meeting quality performance standards and their savings threshold, 125 Accountable Care Organizations qualified for shared savings payments. Since the passage of the Affordable Care Act, more than 470 Medicare Accountable Care Organizations – serving nearly 8.9 million Medicare beneficiaries – have been established through the Medicare Shared Savings Program, the Pioneer Accountable Care

Organization Model, the Next Generation Accountable Care Organization Model, and the Comprehensive End-Stage Renal Disease Care Model.

“Accountable Care Organization initiatives in Medicare continue to grow and achieve positive results in providing better care and health outcomes while spending taxpayer dollars more wisely,” said Dr. Patrick Conway, CMS Principal Deputy Administrator and Chief Medical Officer. “CMS continues to work and partner with providers across the country to improve the way health care is delivered in the United States.”

Accountable Care Organizations were created to change the incentives for how medical care is delivered and paid for in the United States, moving away from a system that rewards the quantity of services to one that rewards the quality of health outcomes. They are groups of doctors, hospitals, and other health care providers who voluntarily come together to develop and execute a plan for a patient’s care and share information, putting the patient at the center of the health care delivery system. In addition, under the proposed Quality Payment Program, health care providers that sufficiently participate in advanced tracks of Medicare Accountable Care Organizations may qualify for exemption from payment adjustments under the Merit-based Incentive Payment System, as well as the additional incentive payments available beginning in 2019 for participation in Advanced Alternative Payment Models.

The Affordable Care Act provides tools, such as Medicare Accountable Care Organizations, to move our health care system toward one that provides patients with high-quality, cost-effective care. The announcement is part of the Administration’s broader strategy to improve the health care system by paying providers for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality. These efforts support the [Administration’s goal](#) to have 50 percent of traditional Medicare payments flowing through alternative payment models by 2018 (already, 30 percent of Medicare payments go through alternative models).

For more detailed information on the quality and financial results, please visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html>

For additional information on the Medicare Shared Savings Program, please visit:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>

For additional information on the Pioneer Accountable Care Organization Model, please visit:

<https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>

###

Guidance on Health Coverage Tax Credit Hardship Exemption is Available

CMS released [guidance](#) that provides information about a hardship exemption that may be claimed through the tax filing process for individuals who qualify for the Health Coverage Tax Credit (HCTC) but who are not enrolled in HCTC-qualifying health insurance coverage. This hardship exemption applies only for certain months in 2016.

###

Upcoming Webinars and Events and Other Updates

IMPACT Act: Data Elements and Measure Development Call

Thursday, October 13, 2016 - 1:30 PM - 3:00 PM Eastern Time

CMS will host an MLN Connects National Provider Call for SNFs, IRFs, LTCHs, HHAs, and other interested stakeholders. Subject matter experts will discuss how data elements fit within measure development and provide an example of the process using the Pressure Ulcer measure. [The Improving Medicare Post-Acute Care Transformation \(IMPACT\) of 2014](#) requires the reporting of standardized patient assessment data by Post-Acute Care providers.

To register or for more information, visit [MLN Connects Event Registration](#).

###

2016 Health Insurance Marketplace Training Calendar for CMS Partners

<https://marketplace.cms.gov/technical-assistance-resources/training-materials/2016-marketplace-training-calendar.pdf>

###

HRSA's Open Funding Opportunities

[Rural Health Network Development Program \(HRSA-17-018\)](#) - Closing Date: November 28, 2016

Executive Summary: The purpose of this program is to support rural integrated health care networks that have combined the functions of the entities participating in the network in order to: achieve efficiencies; expand access to, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole.

[Nursing Workforce Diversity \(NWD\) Program](#) (HRSA-17-063) - Due Date for Applications: November 14, 2016

Executive Summary: The Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Division of Nursing and Public Health, is accepting applications for the fiscal year (FY) 2017 Nursing Workforce Diversity (NWD) program. The purpose of this grant program is to increase educational opportunities for individuals from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses). The overarching goal of the NWD program is to increase access to high quality, culturally-aligned registered nurse providers that reflect the diversity of the communities in which they serve. This goal is accomplished by assisting students from disadvantaged backgrounds to become registered nurses, facilitating diploma or associate degree registered nurses to become baccalaureate-prepared registered nurses, and preparing practicing registered nurses for advanced nursing education.

###

Strategies for Providing Health Care for Frequent Users in Rural Communities

Thursday, October 6, 2016 | 2-3:15 p.m. ET

Access to health care and other critical services in rural communities is impacted by various factors from travel distances between locations to limited financial resources and provider capacity. Community health centers, supportive housing and social service providers, and other health system providers can benefit a great deal from partnerships that address social determinants of health and enable them to share information, coordinate successful strategies, and leverage resources.

This webinar will focus on:

- Understanding the characteristics and needs of the frequent user population in rural communities
- (Re)introducing the key "operators" and their roles in rural communities serving high-utilizers
- Highlighting strategies that are working to leverage both housing and health care resources.

The panelists will emphasize how they went about building their partnerships, the structure that addresses the needs in their communities, and the ongoing benefits.

Presenters (Tentative):

- **Jane Bilger**, Senior Program Manager, CSH

REGISTER NOW

Rural Homelessness Resources from the National HCH Council

Find helpful publications, research reviews, and additional resources on rural homelessness and health care on our [Rural Issues](#) page.

###

FUNDING OPPORTUNITY: Missouri Family Health Council Title X RFA

Missouri Family Health Council, Inc. (MFHC) is announcing the anticipated availability of funds for the provision of Title X family planning services for the fiscal years (FY) of 2017 – 2020. The objective of this Request for Applications (RFA) is to solicit applications from organizations interested in delivering family planning services through the MFHC Title X Network.

Applications for the FY 2017 - 2020 Title X Network must be received and date-stamped by the MFHC office no later than 5:00 p.m., CST, Monday, October 31, 2016. Faxed or electronic applications will not be accepted. MFHC reserves the right to amend or cancel this solicitation.

This RFA, along with fillable forms and supporting documents/information necessary for completing this application are available on the <http://www.mfhc.org/rfa>.

This request is open to all organizations interested in delivering services through the MFHC Title X system.

Please be sure to read the instructions and pay particular attention to bolded areas and required items. If you have any questions, or need clarification in completing this application for funding, questions must be in writing and submitted electronically to rbeul@mfhc.org. Answers to all questions (Q & A) will be available on the [MFHC website](#).

###

A New Look for Think Cultural Health! HHS Office of Minority Health

The Office of Minority Health at the U.S. Department of Health and Human Services is pleased to announce the launch of Think Cultural Health's newly redesigned website! Please visit www.ThinkCulturalHealth.hhs.gov and check out the new site. The Think Cultural Health website now includes designs that feature a simpler layout and brighter colors. It's also mobile ready and can be accessed anytime from your cell phone, tablet and lap top and desk top computers.

Our goal is to offer engaging and practical tools to increase public awareness and understanding of culturally and linguistically appropriate services (CLAS) that are available to all. The new Think Cultural Health website design makes it easier for anyone to browse the latest resources and find information that will help individuals and organizations deliver respectful, understandable, and effective services to all. Start exploring today!

[The National CLAS Standards section](#) features an explanation of CLAS, a printable list of the *Standards*, the comprehensive technical assistance document called [The Blueprint](#), and more.

[The Education section](#) features e-learning programs designed for disaster personnel, nurses, oral health professionals, physicians, community health workers, and more.

[The Resources section](#) features a searchable library of 500+ online resources, recorded presentations, educational video units on CLAS, and more.

We invite you to visit the [new Think Cultural Health website today](#), [share it with your colleagues](#), and [let us know what you think!](#)

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