

# CMS Region 7 Updates

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## ACA/Marketplace Updates

### Administration Launches New Campaign to Enroll Young Adults During Open Enrollment

On September 27th, the Centers for Medicare and Medicaid Services (CMS) announced [new 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. Today, 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. Today, 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.

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### 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.

###

## 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. Today 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.
- 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. 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, 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. For more information on this campaign, click [here](#).

###

## New College Scorecard Program Connects Consumers to Funding and Education Opportunities

The benefits of a college degree, statistically, show that bachelor’s degree recipients earn \$1 million more in their lifetime compared to high school graduates. The Free Application for Federal Student Aid (FAFSA) helps provide \$150 Billion in federal financial aid to individuals who wish to pursue a college education. This aid provides an opportunity for individuals and their families to gain the knowledge and skills needed to succeed in the workforce and strengthen their communities.

In your work with Medicaid and CHIP consumers, let them know about [College Scorecard](#). The U.S. Department of Education just announced this new platform designed to help consumers find the university and program that’s right for them and is the first to provide comprehensive data on costs and student outcomes at many universities in the United States. Now, consumers can search for the earnings of the students who attended a university and the quality of the education provided.

For more information on going to college and getting financial aid, check out this [factsheet](#) on the College Score card or this [video](#) on how the College Scorecard can help you find a good-value school.

###

## **Beware of Fake IRS Tax Bill Notices**

The Internal Revenue Service and its Security Summit partners are warning taxpayers and tax professionals of fake IRS tax bills related to the Affordable Care Act.

The IRS has received numerous reports of scammers sending a fraudulent version of a notice- labeled CP2000 - for tax year 2015.

This scam may arrive by email, as an attachment, or by mail. It has many signs of being a fake:

- The CP2000 notices appear to be issued from an Austin, Texas, address;
- The letter says the issue is related to the Affordable Care Act and requests information regarding 2014 coverage;
- The payment voucher lists the letter number as 105C;
- Requests checks made out to I.R.S. and sent to the “Austin Processing Center” at a post office box.

IRS impersonation scams take many forms: threatening phone calls, phishing emails and demanding letters. Learn more at [Reporting Phishing and Online Scams](#). The IRS does not initiate unsolicited email contact or contact by social media.

An authentic CP2000 notice is used when income reported from third-party sources such as an employer does not match the income reported on the tax return. Unlike the fake, it provides extensive instructions to taxpayers about what to do if they agree or disagree that additional tax is owed. A real notice requests that checks be made out to “United States Treasury.”

The IRS and its Security Summit partners – the state tax agencies and the private-sector tax industry – are conducting a campaign to raise awareness among taxpayer and tax professionals about increasing their security and becoming familiar with various tax-related scams. Learn more at [Taxes. Security. Together.](#) or [Protect Your Clients; Protect Yourself.](#)

###

## **Affordable Care Act has Strengthened Medicare Advantage and Prescription Drug Program**

*From Sean Cavanaugh, Deputy Administrator and Director of the Center for Medicare: Medicare*

Advantage is yet another area where the promise of the Affordable Care Act – saving money and improving care – has been fulfilled. When Congress passed the landmark Affordable Care Act six years ago, some critics claimed the law had fatally undermined the Medicare Advantage program. Yet, each year since then, the Centers for Medicare & Medicaid Services (CMS) has reported data showing this doom and gloom scenario was wrong. In spending taxpayers’ and beneficiaries’ dollars more wisely, the Affordable Care Act’ reforms resulted in a rejuvenated Medicare Advantage program that has grown every year while premiums have been stable and quality has improved.

For details on how the ACA strengthened the Medicare Advantage and Prescription Drug Programs, click [here](#).

###

## ASPE Off Marketplace Datapoint

Today, HHS released a new report showing that 2.5 million Americans who currently purchase off-Marketplace individual market coverage may qualify for tax credits if they shop for 2017 coverage through the Marketplaces.

“More than 9 million Americans already receive financial assistance through the Health Insurance Marketplace to help keep coverage affordable, but today’s data show millions more Americans could benefit,” said HHS Secretary Sylvia Burwell. “Marketplace consumers who qualify for financial assistance usually have the option to buy coverage with a premium of less than \$75 per month.”

To read today’s press release, please visit: <http://www.hhs.gov/about/news/2016/10/04/new-analysis-shows-americans-currently-buying-individual-health-coverage-off-marketplace.html>

To find the **report**, visit: <https://aspe.hhs.gov/pdf-report/people-who-currently-buy-individual-market-coverage-could-be-eligible-aca-subsidies>

Please help us to amplify this news on social media using any of the below sample tweets and attached graphic:

- 2.5M who buy individual health coverage off-Marketplace may qualify for [#HealthCareGov/#ACA] tax credits [& cheaper #ACA Marketplace options].
- 2.5M who buy individual coverage off-Marketplace may be eligible for #ACA financial assistance to #GetCovered.
- Buy individual coverage off-Marketplace? You may be one of the 2.5M eligible for financial help through @HealthCareGov.
- Evaluate your @HealthCareGov options during Open Enrollment. You may be eligible for financial help.
- Financial help could be available to 2.5M Americans with individual coverage off-Marketplace.
- #ACA tax credits may be available to 2.5M Americans who currently buy individual coverage off-Marketplace.
- Simply put, millions more Americans could qualify for #ACA tax credits that make their 2017 coverage more affordable.

###

## ASPE Report: The Effect of Medicaid Expansion on Marketplace Premiums

States that have expanded Medicaid coverage under the ACA effectively have private insurance risk pools comprised largely of individuals with incomes above 138% FPL, since those with incomes below this level are covered by Medicaid. In non-expansion states, individuals with incomes below 100% FPL generally have no option for subsidized coverage, but individuals with incomes in the 100%-138% FPL range can access financial assistance through the Marketplace. In these states, individuals with incomes between 100 and 138% FPL make up close to 40% of the Marketplace population, on average, versus 6% in states that have expanded Medicaid. Because low-income individuals on average have poorer health status than those with higher incomes (but better health status than those with incomes below poverty), a state’s decision to expand Medicaid has the potential to affect the individual market risk pool and ultimately Marketplace premiums. The report is available online at:

<https://aspe.hhs.gov/sites/default/files/pdf/206761/McaidExpMktplPrem.pdf>

###

## Quality Star Rating Pilot Bulletin

CMS released the pilot display of QRS star ratings in two FFM States for the 2017 individual market open enrollment period. CMS' goals with the 2016 consumer pilot testing include:

- Obtaining further details about consumer understanding and use of QHP quality rating information during an actual open enrollment period to inform QRS star ratings' display; and
- Informing the development of comprehensive technical assistance and education related to the QRS for assisters, navigators, agents, brokers and consumer groups prior to QRS public reporting.

CMS will be able to collect data to support the above stated goals and inform the future display of QHP quality rating information to consumers beyond 2017 by using this limited pilot approach. QHP issuers participating in the Marketplaces in the selected States will receive targeted outreach from CMS Account Managers with additional information. CMS will also conduct targeted outreach to State regulators in pilot States. This guidance updates the QSR bulletin released April 29, 2016.

(<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QRS-Bulletin-4-29-2016.pdf>).

The report can be found on CCIIO's website here: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/UpdatedQualityPilotGuidance09302016FINAL.pdf>

###

## Administration Launches New Campaign to Enroll Young Adults During Open Enrollment

CMS [announced](#) new strategies, new tools, and new partnerships 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.

###

## Every Income Group Experienced Significant and Similar Drops in Uninsured Rates Under the Affordable Care Act

U.S. Department of Health and Human Services [released](#) new research analyzing gains in health insurance coverage from 2010-2015 across key demographic categories of Americans: income, age, geography, race and ethnicity. The report finds that ACA coverage gains have been widely shared across groups. For example, the uninsured rate fell by around 40 percent for Americans in all income groups for 2010 through 2015, including individuals with incomes above 400 percent of the federal poverty level (FPL).

###

## Issuers Must Prominently Display Required Rate Filing Information

CMS released a [bulletin](#) to provide additional guidance on the reporting requirements that must be met by

health insurance issuers that implement rate increases determined by CMS or a State to be unreasonable. The bulletin explains the manner in which an issuer must “prominently post” the required rate filing information and its Final Justification for implementing a rate increase deemed to be “unreasonable” and clarifies the type of information that an issuer must include in its Final Justification.

###

## Health Insurance Marketplace Logo

The Centers for Medicare & Medicaid Services (CMS) is instructing all its partners to discontinue use of the old Health Insurance Marketplace logo, and to destroy any printed materials that feature the old Marketplace logo. (The old Marketplace logo features a stylized H-type graphic in front of the “Health Insurance Marketplace” text, as displayed below.)

This is an example of the old logo:



And here is an example of the new logo:

Health Insurance Marketplace

\*\*\*Be advised that insurance agents/brokers/brokerages are not permitted to use the old or new Marketplace logo, as that would imply CMS or the Federal Government endorses said agent, etc., which is legally prohibited under Section 1140 of the Social Security Act.\*\*\*

###

## Medicare and Medicaid Updates

### CMS Selects Quality Improvement Organization to Support Quality Improvement at Indian Health Service Hospitals

The Centers for Medicare & Medicaid Services (CMS) awarded a new contract to help support best health care practices and other operational improvements for Indian Health Service (IHS) federal government operated hospitals that participate in the Medicare program. HealthInsight, a current Quality Innovation Network – Quality Improvement Organization (QIN-QIO), will partner with IHS hospitals to continuously improve the quality of care for the Medicare patients they serve. These efforts will also benefit other patients receiving care at the same facilities. This award is part of a larger IHS quality initiative supported by the Department of Health and Human Services (HHS) Executive Council on Quality Care led by HHS Acting Deputy Secretary Mary K. Wakefield. With this collaborative strategy, IHS and CMS are working together to achieve and sustain improvements in quality of care.

“Our top priority is the health and safety of patients that seek care at facilities we oversee. I am incredibly excited by this opportunity to bring resources and support to American Indian and Alaskan Native patients to improve the delivery of high quality care to patients,” said Patrick Conway, M.D., CMS Acting Principal Deputy Administrator and Chief Medical Officer. “Our QIN-QIO is well poised to assist with this transformation and will work with the Indian Health Service hospitals and clinicians to ensure beneficiaries get the best possible care.”

“Today’s announcement underscores the IHS commitment to ensuring that every IHS hospital, clinic and health center provides high-quality health care to our patients,” said IHS Principal Deputy Director Mary L. Smith. “IHS hospitals – and our staff members across the country – are focused on continuous improvement. The QIO will provide training for our staff and access to experts to strengthen IHS capacity to deliver quality health care for American Indian and Alaska Native patients.”

The overarching goals for the QIN-QIO are to support, build, and redesign if needed IHS hospital operating infrastructure in order to provide high-quality health care services to Medicare beneficiaries. The contract will focus on leadership, staff development, data acquisition and analytics, clinical standards of care, and quality of care related to the Medicare program. CMS expects that this work, while focused on Medicare beneficiaries, will result in systemic change that improves all of the care provided at these facilities. Over the course of the contract (approximately three years), the QIN-QIO will:

- Develop effective leaders through training and networking;
- Build strong hospital systems through team based care and clinical quality improvement;
- Strengthen patient, family, and tribal engagement at the project and local levels;
- Promote and spread best practices in hospitals through Web-based Learning & Action Networks and direct technical assistance;
- Ensure that clinical, operational, and safety standards are met or exceeded;
- Assist with the development of hospital improvement plans; and
- Establish baseline data to ensure plans for improvement are successful and sustainable.

This action expands upon the May 2016 announcement of a [CMS and IHS partnership to reduce hospital acquired conditions and avoidable readmissions](#).

HealthInsight is the current QIN-QIO for the southwest region of the U.S., where many IHS federal government operated hospitals are located. HealthInsight has a history of strategic partnerships that support quality improvement and innovation in hospitals across multiple states.

IHS quality efforts are driven by its draft [Quality Framework, developed in consultation with Tribal Leaders](#) from July through October 2016. The IHS Quality Framework aims to develop, implement, and sustain an effective quality program that: improves patient experience and outcomes; strengthens organizational capacity; and ensures the delivery of reliable, high quality health care for IHS federal government operated facilities.

The IHS, an agency in the U.S. Department of Health and Human Services, provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives.

###

### **340B Pharmacy Program**

The 340B Program enables covered entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Manufacturers participating in Medicaid, agree to provide outpatient drugs to covered entities at significantly reduced prices.

Eligible health care organizations/covered entities are defined in statute and include HRSA-supported health centers and look-alikes, Ryan White clinics and State AIDS Drug Assistance programs, Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers.

[See the full list of eligible organizations/covered entities.](#)

###

### **AHRQ, CMS Award \$13 Million to Test and Implement New Children's Quality Measures**

The Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) announced today awards totaling \$13.4 million in funding over four years to six new Pediatric Quality Measures Program (PQMP) grantees focused on implementing new pediatric quality measures developed by the PQMP Centers of Excellence (COE).

Quality measures are used to evaluate or quantify specific health care processes, outcomes, patient perceptions, or other factors related to health care delivery. The pediatric quality measures are used by state Medicaid and Children's Health Insurance Programs (CHIP) and other public and private programs, providers, plans, patients, and their families to measure and improve the quality of children's health care.

The PQMP was initially established in 2011 by AHRQ and CMS under Title IV of the Children's Health Insurance Program Reauthorization Act (CHIPRA) with the aim of increasing the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services. The initial phase of the PQMP funded seven COEs to develop new and innovative pediatric measures. This next phase of work will implement and test these newly developed pediatric measures in real-world settings to learn more about how they work when used in the front lines of care.

The new grantees will have two key goals focused on assessing the feasibility and usability of the new measures within the Medicaid and CHIP patient populations at the state, health plan, and provider levels to support performance monitoring and quality improvement.

“The PQMP Centers of Excellence provided us with valid measures of children’s health care quality. This next step of research will help us test these measures in real-world settings,” said AHRQ Director Andy Bindman, M.D. “The ultimate goal is to improve children’s health through better health care, at lower costs, at both the Federal and state level.”

“Medicaid and CHIP give millions of children in the United States a healthy start. Through efforts such as this Pediatric Quality Measures Program funding, we are able to advance states’ efforts to measure and report meaningful improvements in the quality of care for children,” said Vikki Wachino, Director, Center for Medicaid and CHIP Services (CMCS).

This new effort is funded through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), (Public Law 114-10 Section 304(b)), which provided continued funding for the Pediatric Quality Measure Program to build knowledge and evidence to support performance monitoring and quality improvement for children in Medicaid and CHIP.

For more information, visit <http://www.ahrq.gov/policymakers/chipra/pqmp.html> and <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html>.

###

## **CMS Awards \$347 Million To Continue Progress Toward A Safer Health Care System**

*Hospital Improvement and Innovation Networks to continue patient safety improvement efforts started under the Partnership for Patients initiative*

The Centers for Medicare & Medicaid Services (CMS) awarded \$347 million to 16 national, regional, or state hospital associations, Quality Improvement Organizations, and health system organizations to continue efforts in reducing hospital-acquired conditions and readmissions in the Medicare program. The Hospital Improvement and Innovation Network contracts awarded today build upon the collective momentum of the Hospital Engagement Networks and Quality Improvement Organizations to reduce patient harm and readmissions. This announcement is part of a broader effort to transform our health care system into one that works better for the American people and for the Medicare program. The Administration has a vision of a system that delivers better care, spends our dollars in a smarter way, and puts patients in the center of their care to keep them healthy.

“We have made significant progress in keeping patients safe – an estimated 2.1 million fewer patients harmed, 87,000 lives saved, and nearly \$20 billion in cost-savings from 2010 to 2014 – and we are focused on accelerating improvement efforts,” said Patrick Conway, M.D., CMS acting principal deputy administrator and chief medical officer. “The work of the Hospital Improvement and Innovation Networks will allow us to continue to improve health care safety across the nation and reduce readmissions at a national scale – keeping people as safe and healthy as possible.”

“America’s hospitals embrace the ambitious new goals CMS has proposed,” said Rick Pollack, president and CEO of the American Hospital Association (AHA). “The vast majority of the nation’s 5,000 hospitals were involved in the successful pursuit of the initial Partnership for Patients aims. Our goal is to get to zero

incidents. AHA and our members intend to keep an unrelenting focus on providing better, safer care to our patients -- working in close partnership with the federal government and with each other.”

Building on this shared success, new, ambitious goals have been set for the Hospital Improvement and Innovation Networks. Through 2019, these Hospital Improvement and Innovation Networks will work to achieve a 20 percent decrease in overall patient harm and a 12 percent reduction in 30-day hospital readmissions as a population-based measure (readmissions per 1,000 people) from the 2014 baseline.

The establishment of these new goals raises the bar for improvements in patient safety in the acute care hospital setting. The newly identified goal of a 20 percent reduction in all-cause patient harm will continue the strong momentum in improving the quality of care delivered to Medicare patients. The goal for harm reduction set forth during the initial phases of Partnership for Patients periods was to decrease preventable patient harm by 40 percent. These efforts resulted in a 39 percent decrease in preventable all-cause harm compared to a 2010 baseline rate of 145/1000, which equated to a 17 percent reduction in overall harm. The even more ambitious goal of a 20 percent reduction in overall harm is based on a 2014 baseline of 121 harms/1000 and aims to achieve a rate of 97 harms/1000 by the end of 2019.

Debra L. Ness, President of the National Partnership for Women & Families, applauded the new awards: “Patients and families will benefit immensely from the continuation of the Partnership for Patients’ important work, which was begun in the CMS Innovation Center. Innovative approaches to systematically include patients and families in this intensive improvement work have resulted in unprecedented national reductions in harm. We are confident that the more ambitious aims being announced today – and the continued engagement of patients and families in this work – will continue the progress.”

Expanding the focus for the Hospital Improvement and Innovation Networks to include a reduction in all-cause patient harm supports the development of an overall culture of safety in the nation’s hospitals by creating an environment that supports a high quality, patient-centered approach to care delivery.

Hospital Improvement and Innovation Networks will also work to expand and develop learning collaboratives for hospitals and provide a wide array of initiatives and activities to improve patient safety in the Medicare program. They will be required to address a wide variety of topics, including:

- Adverse drug events (to focus on at least the following three medication categories: opioids, anticoagulants, and hypoglycemic agents)
- Central line-associated blood stream infections (in all hospital settings)
- Catheter-associated urinary tract infections (in all hospital settings)
- *Clostridium difficile* infection (including antibiotic stewardship)
- Injury from falls and immobility
- Pressure Ulcers
- Sepsis and Septic Shock
- Surgical Site Infections (for multiple classes of surgeries)
- Venous thromboembolism (at a minimum in all surgical settings)
- Ventilator-Associated Events
- Readmissions

Efforts to address health equity for Medicare beneficiaries will be central to the Hospital Improvement and Innovation Networks efforts. CMS will monitor and evaluate the activities of the Hospital Improvement and Innovation Networks to ensure that they are generating results and improving patient safety.

The 16 organizations (listed in alphabetical order) receiving contracts in the Hospital Improvement and Innovation Networks are:

- Carolinas Healthcare System
- Dignity Health
- Healthcare Association of New York State
- HealthInsight
- The Health Research and Educational Trust of the American Hospital Association
- Health Research and Educational Trust of New Jersey
- Health Services Advisory Group
- The Hospital and Healthsystem Association of Pennsylvania
- Iowa Healthcare Collaborative
- Michigan Health & Hospital Association (MHA) Health Foundation
- Minnesota Hospital Association
- Ohio Children’s Hospitals’ Solutions for Patient Safety
- Ohio Hospital Association
- Premier, Inc.
- Vizient, Inc.
- Washington State Hospital Association

The Partnership for Patients model is one of the first models established in 2011 to be tested under the authority of section 1115A of the Social Security Act (the Act) with the goal of reducing program expenditures while preserving or enhancing the quality of care. Since the launch of the Partnership for Patients and the work of Hospital Engagement Networks in collaboration with many other stakeholders, the vast majority of U.S. hospitals have delivered results as demonstrated by the achievement of unprecedented national reductions in harm. CMS believes that the upcoming work of the Hospital Improvement Innovation Networks, working as part of the Quality Improvement Organization’s work to improve patient safety and the quality of care in the Medicare program, will continue the great strides made in improving care provided to beneficiaries.

For more information on this announcement, please visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-09-29-2.html>.

###

## **The Medicare Current Beneficiary Survey: Celebrating Our 25<sup>th</sup> Anniversary and a Bright Future Ahead - Niall Brennan, Chief Data Officer, CMS**

This year marks the 25<sup>th</sup> anniversary and the one millionth beneficiary interview for the Medicare Current Beneficiary Survey (MCBS), a survey that the Centers for Medicare & Medicaid Services (CMS) first fielded in 1991. This in-person survey of 15,000 Medicare beneficiaries collects valuable information about aspects of the Medicare program that cannot be analyzed based on CMS administrative data alone. In particular, the MCBS gathers information on self-reported health status, satisfaction with care, and functional limitations. The MCBS also collects information on beneficiaries that is key to understanding patient-centered care. Beneficiary’s out-of-pocket spending and source of payment for medical services received outside the Medicare program provides a window into the “invisible” and missed costs of health care. One unique aspect of the MCBS is that it includes beneficiaries who reside in institutional settings, such as a nursing home, as well as those in the community.

The MCBS is used across CMS to provide important insights that support internal program analyses. For example, over the past several years, the MCBS has become a key resource for evaluating the impact of CMS Innovation Center demonstration models as well as for approving Medicare Advantage and Prescription Drug Plan benefits.

The MCBS also serves as the foundation for thousands of health policy analyses across a diverse external user community. To date, we know of more than 1,000 peer-reviewed papers based on MCBS data in leading publications such as the New England Journal of Medicine, the Journal of the American Medical Association, Journal of Health Economics, and the Journal of the American Geriatrics Society.

Today, I want to acknowledge a number of important efforts CMS has undertaken to ensure the MCBS remains a valuable resource for the agency and external stakeholders. We have made the data more accessible, releasing the first ever MCBS public use file in May of this year. While MCBS data files have always been available for a relatively nominal fee, we heard that this fee was a barrier to entry for certain users such as students. We believe that increased access through this freely available public resource will expand the MCBS user community, and thus help cement its importance as a critical tool in the evaluation of systemic changes in the US health care delivery system.

We are also implementing changes to the MCBS questionnaire and survey design. Revising and improving the survey questions is underway. We have added new relevant content including an updated dental utilization module, a module on care coordination, and new questions on food security. Enhancing the sampling methodology to include newly enrolled beneficiaries in the first year of their Medicare enrollment, conducting an oversample of Hispanic beneficiaries, and, beginning in 2017, conducting an oversample of low-income beneficiaries increase our ability to conduct disparities research and improve our survey estimates.

We are also committed to a more rapid data release schedule, with improved user documentation and file structure. The 2015 MCBS files will be the first to have many of the improvements discussed above. We anticipate releasing the 2015 data file in the 2<sup>nd</sup> quarter of 2017, more than one year earlier than the previous file release schedule. The release of the 2015 data will also include improved chart books to accompany data releases and more intuitive naming conventions and file layouts with modern file formats for SAS, Stata, and R use. However, to accommodate these long overdue innovations, we had to make the difficult decision not to release 2014 data files.

As we celebrate our 25<sup>th</sup> anniversary of the MCBS, we are renewing our commitment to providing the most useful and relevant information about the Medicare program and, more importantly, the health and satisfaction of its beneficiaries.

We hope that you'll visit us on our MCBS webpage at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/index.html> where you can also subscribe for important updates and announcements.

###

## **Learn About Important Changes to the EHR Incentive Programs**

The Centers for Medicare & Medicaid Services (CMS) recently released two proposed rules and a final rule that will affect the future of the Medicare and Medicaid EHR Incentive Programs. These include the:

FY 2017 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes [final rule](#).

The [FY 2017 Hospital IPPS final rule](#) includes changes that require providers to report four quarters of data for eight of the fifteen Hospital IQR clinical quality measures (CQMs). These changes have been made to reduce reporting burden and align program requirements, and would apply to the 2019 payment determination.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) [proposed rule](#).

The [MACRA proposed rule](#) establishes the Quality Payment Program (QPP), which is set to begin January 1, 2017. Starting in 2017, Medicare EPs will participate in the QPP instead of the Medicare EHR Incentive Program. (*Note: This does not apply to Medicaid-only EPs.*)

During 2017, eligible physicians and other clinicians will be able to “pick their pace,” and will have four options for participation in the QPP. By choosing one of these options, physicians will avoid a negative payment adjustment in 2019. For specific details about the participation options, see the CMS blog post: [Plans for the Quality Payment Program in 2017: Pick Your Pace](#).

Calendar Year (CY) 2017 Changes to the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) [proposed rule](#).

The [CY 2017 OPPS ASC proposed rule](#) recommends:

- Eliminating the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures beginning in 2017; and reducing the thresholds for a subset of the remaining objectives and measures in Modified Stage 2 in 2017 and Stage 3 in 2017 and 2018 for eligible hospitals and critical access hospitals (CAHs) attesting under the Medicare EHR Incentive Program.
- Requiring new participants (eligible professionals [EPs], eligible hospitals, and CAHs) to attest to Modified Stage 2 by October 1, 2017 to avoid the 2018 Medicare payment adjustment.
- Revising the EHR reporting period in 2016 to a minimum of 90 consecutive days for all returning participants.
- Modifying measure calculations for actions outside the EHR reporting period.
- Allowing certain EPs to apply for a significant hardship exception from the 2018 Medicare payment adjustment if they are: new participants who intend to attest to meaningful use for an EHR reporting period in 2017, or who intend to transition to the Merit-based Incentive Payment System (MIPS) and report on measures specified for the Advancing Care Information Performance Category.

## For More Information

To learn more about the future of the EHR Incentive Programs, visit the [CMS EHR Incentive Programs website](#). CMS will continue to update the website to include additional information and resources for EPs, eligible hospitals, and CAHs. Stay tuned!

###

## Medicare Learning Network

### [News & Announcements](#)

- [CMS Finalizes Improvements in Care, Safety, and Consumer Protections for Long-Term Care Facility Residents](#)
- [CMS Awards \\$347 Million to Continue Progress toward a Safer Health Care System](#)
- [HH Quality of Patient Care Star Ratings and HH Compare Preview Reports Available](#)
- [New Electronic Appeals System: MOD E-File Available](#)
- [New EHR Contract Guide and Health IT Playbook](#)

- [EHR Incentive Programs: Learn About Important Changes](#)
- [EHR Incentive Programs: 2016 CQM Requirements](#)
- [October is National Breast Cancer Awareness Month](#)

#### [Provider Compliance](#)

- [Automatic External Defibrillators: Inadequate Medical Record Documentation](#)

#### [Claims, Pricers & Codes](#)

- [Billing for Influenza: New CPT Code 90674](#)

#### [Upcoming Events](#)

- [IMPACT Act: Data Elements and Measure Development Call — October 13](#)
- [Physician Compare Public Reporting Information Sessions — October 18 and 19](#)
- [2015 Supplemental QRUR Physician Feedback Program Call — October 20](#)
- [Long-Term Care Facilities: Reform of Requirements Call — October 27](#)
- [How to Report Across 2016 Medicare Quality Programs Call — November 1](#)

#### [Medicare Learning Network® Publications & Multimedia](#)

- [Medicare Part B Drug Average Sales Price Reporting by Manufacturers – Blending National Drug Codes MLN Matters® Article — New](#)
- [Medicare Parts A & B Appeals Process Booklet — Revised](#)
- [Resources for Medicare Beneficiaries Booklet — Revised](#)

###

## 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](#).

###

### Cultural Competency Webinars

[Register here](#)

DATE: October 13, 2016

TIME: 2:00 p.m. – 3:00 p.m. Eastern Daylight Time

Are you interested in learning more about cultural competency and utilizing cultural competency resources to best fit your organizational needs?

The Southeastern Health Equity Council (SHEC) released its Cultural Competency Resource Guide in fall 2015. This guide is comprised of resources, trainers, institutions and publications about cultural and linguistic competency that can be shared with the 10 Regional Health Equity Councils (RHECs), stakeholders and partners to help address cultural barriers with health care systems. Additionally, this guide includes important terms for members of the SHEC to become familiar with as the Council develops a common language around cultural competency. To view the resource guide, visit <http://region4.npa-rhec.org/in-the-spotlight/resourceguidewhitepaper>

To follow up on the release of the Cultural Competency Resource Guide, the SHEC will host three webinars in various regions of the country. The webinars will include speakers from organizations that focus on cultural competency. Upon completion of the first of these webinars – on the Hispanic/Latino population – the participant will be able to accomplish the following from the specific organizational perspective:

1. Define cultural competency;
2. Describe the diversity within the Hispanic/Latino community;
3. Explain the relationships among culture, language and health within the Hispanic/Latino community; and
4. Identify cultural competency assessment and evaluation tools.

The focus of the webinar will be the Community Engagement and Cultural Diversity Program at the Miami Clinical and Translational Science Institute (CTSI) and the services it provides to bring cultural and linguistic assistance to the Hispanic/Latino community in Florida.

Moderator: Bettina Byrd-Giles, Chief Executive Officer, The Bethesda Life Center, Inc.  
& Patria Alguila, Program Coordinator, MHP Salud

Presenter: Brendaly Rodriguez, Manager, University of Miami Clinical and Translational Science Institute  
– Community Engagement and Cultural Diversity Program

###

## Refugee Mental Health

**Friday, October 21, 2016 9:00 - 11:30 a.m.**

Location: Fellowship Hall - First Church of the Nazarene, KC, 11811 State Line Rd. KCMO 64114

Overview: This workshop will provide participants with an overview of the refugee populations currently settling in Kansas City. Elements of the refugee process and experience will be explored and implications for the mental health of refugees and their families discussed. Lenses of culture will be applied to understand symptoms, access and effectiveness of mental health disorders and treatments.

Objectives: After attending this program, the participant will be able to:

- Gain a basic understanding of refugees including the process they go through to resettle in the United States and the services available to them.
- Describe the barriers refugees face that contribute to their mental health problems and needs.
- Discuss the need to adapt services provided in the community to meet the unique needs of refugee clients and suggestions to do so.

Registration Fee: \$20.00. 2.5 CEU's

(Certificate of Attendance)

Pre-register only. Contact Stacy Davis to obtain [registration form](#) or go to [www.mhah.org](http://www.mhah.org) click onto "[Events](#)". If you have any questions and/or need translation or other accommodation, please contact Stacy Davis at [sdavis@mhah.org](mailto:sdavis@mhah.org) or 913-281-2221 ext. 112 at least 5 days prior to the workshop. Registration deadline is October 16, 2016. Make checks payable to MHAH. Accept VISA.

Sponsored by: Mental Health America of the Heartland in collaboration with Catholic Charities of Northeast Kansas.

###

## Creating Inclusive Healthcare Environments

[By: Health Literacy Missouri](#)

WHEN: Thursday, October 20, 2016 from 11:00 AM to 4:00 PM (CDT)

WHERE: Kauffman Foundation Conference Center - 4801 Rockhill Road, Kansas City, Missouri 64110

COST: \$49 per person

This five-hour experiential workshop increases understanding of the value that diversity and inclusion adds to health literacy frameworks through short presentations, experiential activities, reflection and dialogue. Using a Freirean pedagogy, participants are engaged both as learners and teachers, while exploring how social justice theory bridges cultural competency and health literacy to create inclusive health care cultures, environments, and practices. The workshop will explore power in health care by examining who benefits and who is marginalized by the current structure of our health care system. It can help practitioners and

educators in understanding their bias and privilege and the systemic structures that reinforce those elements. Using improved health literacy as a guiding principle, participants will learn strategies to forge partnerships with patients as allies.

Space for this workshop is limited! Note: Tickets for this workshop and the Summit on Friday, October 21st are sold separately

Register at <https://www.eventbrite.com/e/creating-inclusive-healthcare-environments-tickets-25850022112>

Health Literacy Missouri, or HLM, is a nonprofit communications team that specializes in clear health communications. We partner with health-related organizations to close the gap between patient skills and the demands of the health care system. By making health care easier for people to understand and use, we can save lives, save money, and make it easier to get care.

###

## **14th Annual Missouri Health Policy Summit**

Friday, October 28, 2016

Hilton Garden Conference Center • Columbia, Missouri

Registration

[Online Registration](#) • [Registration Form](#)

To register, please complete and return the registration form with payment to the CME office address listed at the bottom of the registration form. You may also register by FAXing your registration form to the CME office at 573/882-5666 or by registering online.

Full-time, residential students may be eligible for complimentary registration. Contact the CME Office for more information: (573)882-3458 or email [Lindsey Beckmann](#)

**PAYMENT METHODS:**

Fees may be paid by cash, check, Discover, MasterCard, Visa or American Express. Checks should be made payable to the University of Missouri.

**SUBSTITUTION/CANCELLATION REFUND POLICY:**

A full refund of fees less a \$25.00 administrative fee will be made if notice of cancellation is received, in writing, by Friday, October 21, 2016. A \$50.00 administrative fee will be assessed for any cancellations received after Friday, October 21, 2016 through Thursday, October 27, 2016. No refunds will be made after October 27, 2016.

###

## **Get Link'd 2nd Annual Conference**

November 15-16, 2016

The Hilton Garden Inn

3300 Vandiver Drive, Columbia, MO

Registration forms and agenda can be found at [www.morha.org](http://www.morha.org)

Please join the Missouri Rural Health Association in Collaboration with Missouri Department of Health and Senior Services & the Missouri Office of Primary Care & Rural Health on November 15-16, 2016 at the Hilton Garden Inn, Columbia, Missouri as we “Navigate the Path to Better Health”.

Our Rural Health Workshops will focus on:

- Health Disparities
- Rural Communities & the Health Insurance Marketplace
- Missouri Rural Hospitals Update
- Recruiting for the Generations
- Alternative Payment Methods
- Navigating Stark and Anti-Kickback Laws

###

## **CMS National Training Program Learning Series Webinar**

October 13, 2016 1:00 – 2:30 pm ET

This webinar will provide information about current topics including:

- Legislation Updates
- CMS Goals and Initiatives
- Medicare Updates
- Medicaid/Children’s Health Insurance Program Updates

To join the webinar, visit <https://goto.webcasts.com/starthere.jsp?ei=1119064>.

###

## **CMS Rural Health Solutions Summit (Save the Date)**

Mark your calendars for the CMS Rural Health Solutions Summit. Join CMS leadership, the CMS Rural Health Council, and stakeholders from all sectors of the health care industry as we engage in in-depth discussions about ways to improve access to care in rural America and support innovation in care delivery.

- Date: Wednesday, October 19, 2016
- Time: 9:00 a.m. – 4:00 p.m.

More information to follow!

###

## **Assister Summit (Save the Date)**

June 28 and 29, 2017

CMS Headquarters in Baltimore, MD

###

## **Video to Assist Agents and Brokers Register and Sell in the Marketplace**

The Health Insurance Marketplace at HealthCare.gov makes it easy for agents and brokers to sell health and dental plans on the Marketplace. [Sell Marketplace Insurance, Build Your Business](#) is a new video for agents and brokers on how to get registered, how to sell, and how to grow their book of business all through HealthCare.gov.

###

## **Plan Year 2017 Open Enrollment: A Primer for Agents and Brokers Participating in the Federally-facilitated Marketplaces (FFMs)**

10/12/2016, 1:00-2:30 PM ET - [Register](#)

###

## **Tips for Assisting Clients in the Small Business Health Options Program (SHOP) Marketplace**

10/11/2016, 3:00-4:00 PM ET - [Register](#)

###

## **Cover Missouri Coalition LearnOn! Marketplace Policies: Most Common and Challenging**

October 27 at 1pm CT

Join us for a webinar to review the most common and challenging policy issues related to the Marketplace and the ACA including Medicaid gap, family glitch, and data matching issues. This webinar is designed to help both new assisters get up to speed on these issues and as a refresher for more experienced assisters.

Register: <https://attendee.gotowebinar.com/register/2493249645921581826>

###

## **Upcoming Assister Webinars**

[Medicare & the Marketplace](#); October 12th from 2:00 – 3:00 pm ET. This webinar will provide information about Medicare and the Marketplace including Medicare eligibility & enrollment, enrollment decisions, transitioning from the Marketplace to Medicare, and resources.

[2017 Overview for Open Enrollment](#); October 14th from 2:00 – 3:00 pm ET

[Marketplace 101](#); October 18th from 2:00 – 3:00 pm ET. This webinar will provide an overview of the Health Insurance Marketplace including who might be eligible, options for those with limited income, the enrollment process, available options for people with Medicare, and resources.

###

## **2016 Health Insurance Marketplace Training Calendar for CMS Partners**

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

###

## **HRSAs' 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.

###

### **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](mailto:rbeul@mfhc.org). Answers to all questions (Q & A) will be available on the [MFHC website](#).

###

### **National Medicare Education Program (NMEP) Meeting**

Wednesday, October 19, 2016 / 1:00 p.m. – 2:30 p.m. EDT

[Register](#)

The focus of the NMEP meeting is to enlist national and local organizations to support outreach and education around the Medicare program. We have expanded the focus of these meetings to reflect additional CMS programs such as Medicaid and the Children's Health Insurance Program. Many national and local organizations that work on behalf of the aged, disabled, the uninsured, children, and families are involved in this public-private partnership. Together with CMS, these partners reach out to other organizations at the state and local levels that in turn work with those eligible for CMS programs to help them understand the health care options available to them.

**If you wish to unsubscribe from future CMS Region 7 emailings, please send an email to Lorelei Schieferdecker at [Lorelei.Schieferdecker@cms.hhs.gov](mailto:Lorelei.Schieferdecker@cms.hhs.gov) with the word "Unsubscribe" in the subject line.**