

CMS Region 7 Updates

10/25/2016

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ACA/Marketplace Updates

2017 Plans Available to Review on Healthcare.gov!

You can now review the 2017 plan options on healthcare.gov to be better prepared to help your consumers next week. Go to <https://www.healthcare.gov/see-plans> to view the plans.

###

Assister Training Now Available in Spanish

Certified application counselors (CACs), Navigators, and in-person assisters in the Federally-facilitated Marketplaces (FFMs) can now access the Spanish language version of the PY2017 Assister Training. To access the training on MLMS, visit the [CMS Enterprise Portal](#). CMS also encourages assisters to [visit the “Training” section of Marketplace.CMS.gov](#) to find materials that will help you access and complete the training, including answers to Marketplace Learning Management System (MLMS) [Frequently Asked Questions \(FAQs\)](#)

Assisters who would like to take the training in Spanish should note that if they have already made course progress using the English curriculum, this will not count towards the Spanish curriculum, and vice versa. Therefore, assisters who start the training in English and want to finish in Spanish will have to start the training again in Spanish.

To access the Spanish training, complete the following steps:

1. From within the CMS Portal, access the MLMS.
2. On the Assister Profile Landing page, select your desired language in the dropdown which says “Select the language in which you would like training content displayed.”
3. Complete the remaining required fields on the Assister Profile Landing Page. Click the “Save/Update” button and then click “Next.”
4. Logout of the CMS Portal and log back in.
5. On the Assister Profile Landing page, select “Next.”
6. The MLMS Assister Landing page appears with the MLMS and the content displaying in the chosen language (e.g. Spanish).

Para conectarse al entrenamiento en español, siga los siguientes pasos:

1. Desde el CMS Portal, entre al MLMS.
2. En la página de perfil de Asistente, seleccione el idioma preferido en la lista desplegable.
3. Complete los campos requeridos en la página de perfil de Asistentes. Haga clic al botón “Save/Update” y luego haga clic en “Next” para avanzar a la página de MLMS.
4. Cierra la sesión del CMS Enterprise Portal y luego re-entre de Nuevo para lograr el cambio de idioma
5. Navegue al MLMS y haga clic en el botón “Next” en la página del perfil.

6. Al ingresar en la página del MLMS notara que la página y el contenido de la misma esta traducida al español, al igual que el contenido del entrenamiento.

###

HHS Collaborates with 17 Companies on Marketplace Outreach

HHS announced a collaboration with 17 companies all committing to connect freelance professionals, entrepreneurs, and customers with information and resources on affordable coverage on the Marketplaces this Open Enrollment period beginning November 1 and ending on January 31.

“We’re excited about this collaboration, which will boost our efforts to reach more Americans than ever this year and help them get covered,” said Secretary Sylvia M. Burwell. “The Marketplaces are already serving entrepreneurs and independent workers across the country, and we want all individuals without workplace coverage to know that thanks to financial assistance, most HealthCare.gov enrollees have coverage options for less than \$75 per month. Open Enrollment for 2017 coverage begins November 1.”

To find today’s **press release**, please visit: <http://www.hhs.gov/about/news/2016/10/25/hhs-collaborates-with-innovative-companies-to-encourage-marketplace-enrollment.html>

Read more about this announcement from an interview with Secretary Burwell on **Recode**: <http://www.recode.net/2016/10/25/13389860/gig-economy-uber-obamacare-burwell>

###

Help Consumers Get ready for 2017 Open Enrollment

Assisters can help consumers get ready to apply for or renew their Marketplace coverage through a variety of resources. Make sure you let consumers know that they can preview 2017 plans and prices on healthcare.gov shortly before November 1st.

First Time Applicants

The following materials are particularly helpful for 1st time applicants to review as they prepare for Open Enrollment:

- Use this **simple checklist to gather documents you’ll need**.
- Get a quick overview of the Health Insurance Marketplace with these [health insurance tips](#).
- See [if you’ll save on health insurance coverage](#) (based on 2016 information, which will change slightly for 2017).
- [Learn how to estimate your income](#) for your application.
- Find [quick answers](#) to popular questions.
- [Find a trained helper in your community by using our Find Local Help page](#) Search by city and state or ZIP code to get personalized help near you.
- Learn the most important insurance terms right now — before you shop: [premium](#), [deductible](#), [copayment](#), [coinsurance](#). [Browse our glossary for more](#).

Returning Applicants (Re-Enrollees)

As you meet with consumers to assist them in re-enrolling in a Marketplace plan, be sure to share with them these important reasons they should update their Marketplace account:

1. **New, affordable plans that meet your needs may be available this year.** Plans and prices change every year. Your situation may have changed too. You may find 2017 plans with coverage and features that better meet your needs — especially if you've had or expect income or household changes.
2. **Update your application so your 2017 financial help is correct.** Financial help is based on your **expected** income for 2017 (**not** last year's income). If you don't update your income and household information, your premium tax credit and other savings could be inaccurate for 2017. If you have the wrong financial help you could wind up paying more for your monthly premium than you have to or you may use more advance payments of the premium tax credit than you qualify for.
3. **You may be automatically enrolled for 2017 — but we strongly recommend you update your application and check out new insurance plans first.** If you don't renew or enroll in a plan by December 15, 2016, you may be [automatically enrolled in the same or a similar plan](#). This way you'll be covered January 1, 2017. But the best way to make sure you have a 2017 plan that meets your current needs, and with the financial help you qualify for, is to log in as soon as November 1, 2016 to update your information and see all the plans available to you for 2017. You should do this even if you want to keep the same plan.
4. **In some cases, you won't be automatically enrolled in the same or a similar plan.** Just enroll in any available plan by December 15, 2016 to make sure you're covered on January 1, 2017

No matter what plan consumers opt to enroll in, the Marketplace **strongly recommends** consumers update their Marketplace application with their most recent income and household information and compare their current plan to what's available for 2017.

Between late September and November 1, 2016, consumers will receive two notices: one from their current insurance company and one from the Marketplace. Together they explain consumers' 2017 coverage status, which plan (if any) they'll be enrolled in or matched with if they don't act by December 15, any changes in their coverage and financial help, and directions if the consumer needs to send the Marketplace any documents.

If a consumer doesn't receive an insurance company notice by November 1, 2016, advise them to contact their insurance company. Similarly, if a consumer hasn't received a Marketplace notice by November 1, 2016, advise them to [contact the Marketplace](#).

###

CMS Details Outreach Campaign Strategy for Open Enrollment 2017

Every year, the Administration gets better and more strategic in our efforts to help millions of Americans enroll in affordable coverage. While the uninsured rate has fallen to the [lowest level on record](#), there are still too many Americans who remain uninsured and experience health and financial hardships resulting from lack of coverage. A key reason people remain uninsured is that they don't know about the options that exist to help them obtain coverage. Experts continue to find that [nearly half](#) of uninsured adults are unaware of the financial assistance available to help pay for health insurance, even though [about 85 percent](#) of Marketplace-eligible uninsured Americans could qualify for financial help.

Outreach is a proven strategy to help Americans understand their health care options and enroll in coverage. Our outreach efforts in previous years have proven very successful in enrolling new consumers. This year, we expect to do even better, as we incorporate best practices from last open enrollment (OE) to make our outreach more efficient and effective. The new strategies the Marketplace will employ for OE4 will focus on:

- **Sending Smarter Emails and Direct Mail** to reach people who were recently uninsured, recently lost coverage, or sought coverage in the past through HealthCare.gov or a state Medicaid program. That includes reaching people who started to sign up at HealthCare.gov last year, but didn't complete the process to sign up for coverage. It also includes sending mail to consumers who lost eligibility for Medicaid or CHIP coverage last year, or who applied for Medicaid or CHIP but had incomes too high to qualify.
- **Expanding our outreach beyond traditional TV and radio outreach** to mobile and streaming platforms, as well as to new channels like gaming platforms that will help reach younger audiences. Recently, we [announced](#) our outreach efforts will include a partnership with Twitch, a social video platform and community for gamers. Today, we're announcing plans to use additional digital platforms to reach young adults including YouTube, Instagram and Facebook.

For more details on the outreach strategy for 2017, click [here](#).

###

NEW Assister Resources

Check out these new Assister resources to use when helping consumers get covered.

Re-Enrollment

- [Updating Your Application](#) (Infographic)
- [Already Have Marketplace Coverage? You Should Still Compare Plans Every Year](#) (Factsheet- [English](#) / [Spanish](#))
- [5 steps to Staying Covered Through the Marketplace](#) (Postcard- [English](#) / [Spanish](#))

Small Businesses

- [5 Questions to Ask Yourself When Choosing Coverage for Your Business](#) (Fact Sheet)
- [The Small Business Health Care Tax Credit & Premium Assistance Programs](#) (Fact Sheet)

Medicaid, Medicare & the Marketplace

- [Apply for Medicaid & CHIP through the Health Insurance Marketplace](#) (Fact Sheet)
- [Marketplace Matters: Medicare & Marketplace](#) (Video)

###

2.5 Million Americans Buying Off-Marketplace Coverage Are likely Eligible for ACA Premium Tax Credits

Since the Affordable Care Act became law, millions of Americans gained coverage or found more affordable options thanks to premium tax credits available through the Health Insurance Marketplace.

Earlier this month, the U.S. Department of Health and Human Services (HHS) [released data](#) 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 Marketplace. Six states (California, Texas, Florida, North Carolina, Illinois, and Pennsylvania) each have more than 100,000 individuals enrolled in off-Marketplace individual market coverage whose incomes may qualify them for Marketplace tax credits.

Many consumers remain unaware of the financial assistance available to them through the Marketplace. In your outreach, education and enrollment efforts, let consumers know that thanks to financial help, most consumers can find a plan with a monthly premium between \$50 and \$100. Share with consumers that:

1. The Marketplace is for people without health coverage through a job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or another source of [qualifying coverage](#). If you don't have health insurance, the Marketplace can help you get covered.
2. What you pay for insurance depends on your income — and you'll [probably save](#)
3. You can apply for coverage online, by phone, with in-person help and with a paper application.
4. If you don't have health insurance, you may have to pay a fee. For 2016, the penalty is either 2.5% of your income, or \$695 per adult (\$347.50 per child) — whichever is higher. The fee rises with inflation. Final 2017 fees will be published soon. [Learn about the fee](#).
5. 2017 Open Enrollment runs from November 1, 2016 through January 31, 2017.

###

Faith Dates of Action

Acacia Bamberg Salatti, Director
Center for Faith-based & Neighborhood Partnerships
U.S. Department of Health & Human Services

Open enrollment for the Health Insurance Marketplace is right around the corner. Starting November 1, members of your community can log in to [HealthCare.gov](#) and enroll in a 2017 health plan- and they can find in-person assistance at [Findlocalhelp.healthcare.gov](#); [EnrollAmericaConnector](#); or [United Way 2.1.1](#).

HHS Secretary Burwell announced this week that there are **10.7 million uninsured** Americans who are eligible for Marketplace coverage with **85 percent of them eligible for** financial assistance, while nearly **60 percent** have incomes that would also qualify them for cost-sharing reductions in addition to tax credits.

We are eager to work with you to spread this good news. Please visit our [website](#) to review this year's 2017 HealthCare Law Toolkit and find helpful information for helping those in your community consider their options for health insurance coverage.

Also find [resources](#) for the faith days action when we heighten our outreach with faith and community organizations to reach community members with timely and important health information. Faith Dates of Action are November 7-14, December 19-24, & January 16-29.

Many of you recognize the importance and challenge of encouraging men to sign up for affordable health insurance. Your community can also help us spread the word about the importance of men's health and enrolling by taking a picture that weekend wearing blue and sharing your photo on social media using the hashtag #LadiesWearBlue. To support men's health and encourage the guys in our lives to enroll, we are

asking ladies to wear blue at services in faith and community settings during the weekend of **November 11th through the 13th**. Be sure to email us at partnerships@hhs.gov if you would like more information or check our website for updates on these efforts.

From this work to connect people to health insurance to webinars on helping vulnerable populations have access to services through mobility management, we are excited to work with you to serve your community. We hope you will join us in these efforts.

###

Think Teeth! Help Improve Oral Health for Kids!

Tooth decay is the most common preventable chronic disease among children in the United States. If left untreated, it can negatively affect a child's physical and social development, as well as his or her school performance. "Think Teeth" is part of an [Oral Health Initiative](#) designed to help ensure that children enrolled in Medicaid and CHIP have easy access [to dental and oral health services](#).

There is also a searchable [database](#) to help consumers find a participating dentist in their community.

Assisters are encouraged to leverage these [materials](#) in their work with consumers to help raise awareness about the importance of oral health for children. The materials are available in English as well as Spanish and include things like:

- [Posters, Flyers](#) and [Tear Pads](#) focused on consumer education that you can [download and customize](#) or [order for FREE](#)
- [Social Media](#) posts, [Facebook](#) and [Twitter](#) images
- [Web Banners and Buttons](#)
- [Widgets](#) to find [Providers](#)

Visit Insurekidsnow.gov for more information on this initiative and how to keep kids healthy.

###

Reminder: Medicare Open Enrollment Takes Place from October 15 – December 7, 2016

The Medicare Open Enrollment period, which began last week, takes place each year from October 15 through December 7. While Marketplace Assisters work primarily to help consumers enroll in coverage through HealthCare.gov, their state Marketplace, or through Medicaid/CHIP, it may be helpful to be aware that Medicare Open Enrollment is currently taking place. For example, if you are working with a family with one or more members eligible for Medicare, you should be aware that this individual will have different coverage needs. Consumers who have become eligible for Medicare may wish to cancel their Marketplace plans. For more information, [click here](#) for details on Medicare Open Enrollment, including state-by-state fact sheets.

For more information on Medicare and the Marketplace, see [this page on HealthCare.gov](#). Assisters can also [click here](#) to learn more about how to help consumers cancel their Marketplace plan once they become eligible for Medicare.

###

CMS Details Outreach Campaign Strategy for Open Enrollment 2017

Outreach is a proven strategy to help Americans understand their health care options and enroll in coverage. CMS incorporates best practices from last open enrollment (OE) to make outreach more efficient and effective. Previous OEs have taught us lessons about effective messages and tactics to reach the uninsured Americans who need information and assistance the most. Marketplace coverage provides consumers with [access to care](#) and [financial protection](#), and Marketplace consumers are as satisfied with their coverage as those with employer-sponsored health insurance. CMS's [data-driven approach](#) will make outreach more effective, helping more people get coverage, stay healthy, and achieve financial security.

###

New Analysis Shows 2.5 million Americans Currently Buying Coverage Off-Marketplace May Be Eligible for Affordable Care Act Premium Tax Credits

U.S. Department of Health and Human Services (HHS) [estimates](#) that about 6.9 million individuals currently purchase health insurance in the off-Marketplace individual market. Of those, about 1.9 million either have incomes that would qualify them for Medicaid or place them in the Medicaid coverage gap or are ineligible to purchase Marketplace coverage due to immigration status, while the remainder could enroll in Marketplace qualified health plans (QHPs).

###

More Than 70 Percent of Consumers Can Find Marketplace Plans for Less than \$75 Per Month

With Start of Window Shopping, Americans Can Now Check Out Options for 2017 Coverage

With window shopping beginning today, Health Insurance Marketplace consumers can now visit HealthCare.gov to check out their options for 2017 coverage in advance of the start of Open Enrollment on November 1. A new [report](#) released today shows that 72 percent of Marketplace consumers in states using HealthCare.gov will be able to find plans with a premium of less than \$75 per month and 77 percent will be able to find plans with premiums below \$100, taking into account financial assistance. The report also shows that consumers will have options, with an average of 30 health insurance plans to choose from.

“Thanks to financial assistance, most Marketplace consumers this year will find plan options with premiums between \$50 and \$100 per month,” said HHS Secretary Sylvia M. Burwell. “Millions of uninsured Americans qualify for financial assistance, and so could as many as 2.5 million Americans currently paying full price for off-Marketplace coverage. I encourage anyone who might need 2017 coverage to visit HealthCare.gov and check out this year’s options for yourself.”

Thanks in large part to the Marketplace, in early 2016, the share of Americans without health insurance fell to [8.6 percent](#), the lowest level in our nation’s history. This year’s Open Enrollment offers the chance to build on that progress and further improve access to care and financial security.

Financial Assistance and Shopping Help Keep Coverage Affordable

Eighty-five percent of current Marketplace consumers receive tax credits that bring down the cost of coverage, and, nationwide, about the same percentage of Marketplace-eligible uninsured Americans also have incomes that could qualify them for tax credits. In addition, an [estimated - PDF](#) 2.5 million people

currently paying full price for health insurance in the off-Marketplace individual market could be eligible for tax credits if they purchase 2017 coverage through the Marketplace.

Tax credits increase dollar-for-dollar with the cost of a consumer's benchmark plan, so they protect the large majority of consumers from rate increases. For example, a 27-year-old in Dallas, Texas with an income of \$25,000 paid \$143 per month to purchase the benchmark (second-lowest cost silver) plan in 2016. For 2017, that same 27-year-old would pay almost the exact same amount for benchmark coverage, despite a premium increase of \$16 per month, because tax credits also increase to compensate.

In addition to financial assistance, shopping helps keep coverage affordable for consumers. If every returning consumer nationwide selected the lowest-cost plan within the same metal level they picked last year, average premiums paid (taking into account financial assistance) would fall by \$28 per month – 20 percent – compared to 2016. In fact, many consumers do not choose the lowest-cost plan available, which is why it's important that shopping also lets consumers compare plans based on factors like provider network, prescription drug coverage, and total out-of-pocket costs. But this calculation confirms that affordable options for 2017 coverage are available to consumers who choose to shop around to find a better deal.

This year, HealthCare.gov consumers will have the option to choose from an average of 30 plans. Like last year, there will be an average of 10 plans per issuer. Four out of five (79 percent of) consumers will also be able to choose between multiple issuers, and all consumers will be able to choose among plans with different combinations of premiums, out-of-pocket costs, networks of hospitals and physicians, and prescription drug coverage options. For people with employer-sponsored health insurance, plan choice is typically narrower; for example, in 2015, [30 percent - PDF](#) of people with employer coverage had only one plan option.

As the Marketplace Goes Through a Transition Year, Experiences Vary Widely Across States

Through 2016, Marketplace rates remained [well below](#) initial projections from the independent Congressional Budget Office, and [well below - PDF](#) the cost of comparable coverage in the employer market. Nationwide, average Marketplace premiums for 2017 are increasing more than they have in the past two years. Even with these adjustments, premiums remain roughly in line with projections issued by the Congressional Budget Office during the debate over the Affordable Care Act (ACA).

Adjustments this year reflect issuers bringing their rates in line with observed costs, now that two years of data are available. In addition, some of the ACA's programs designed to support the new market in its early years are ending this year, putting additional one-time pressure on premium growth. Issuers are continuing to adapt to a new market that looks very different than it did before the ACA: one where they compete based on price and quality, rather than by finding the healthiest customers. Efforts to undermine the ACA, such as certain states' decisions not to expand Medicaid and Congressional actions to block funding for the law, contribute to higher premiums as well. And some states have long faced unique challenges in reining in health care costs.

For the median HealthCare.gov consumer, the benchmark second-lowest silver plan premium is increasing by 16 percent this year, before taking into account the effects of financial assistance; that is, half of HealthCare.gov consumers are seeing increases less than, and half greater than, 16 percent. But experiences across states vary widely. For example, in Arkansas, Indiana, Michigan, Nevada, New Hampshire, New Jersey, North Dakota, and Ohio, as well as in California and Massachusetts (which do not use the HealthCare.gov platform), benchmark premiums are rising by 7 percent or less. In most of these states, Marketplaces are also strongly competitive, and several have seen issuers expanding their service areas, as with Molina in Ohio or Humana in Michigan. These examples illustrate that there are parts of the country where Marketplaces are already maturing, reaching stable price points, and enjoying robust competition.

Conversely, some states are experiencing high benchmark premium growth, resulting in a HealthCare.gov average higher than the median increase. A number of the states in this group, including Arizona, Hawaii, Illinois, Kansas, and Pennsylvania, are places where 2016 rates were especially far below the national average or especially far below the cost of comparable coverage in the employer market.

Fortunately, financial assistance and the ability to shop around for coverage protect most consumers across the country from headline rate increases. “Before the ACA, many consumers were unable to get health coverage at all, and the individual market offered no easy way to shop and compare plans,” said Kevin Coughlin, CEO of the Health Insurance Marketplace. “Because of the Marketplace, consumers can shop around to find coverage that fits their needs and get tax credits to help pay for it. Thanks to shopping and financial assistance, consumers will continue to have robust options for quality, affordable coverage for 2017, even in places where premium increases are high.”

The Affordable Care Act Is Strengthening Coverage, and Improvements Could Drive Further Progress

The Marketplace is one of many ways the ACA continues to improve health care affordability, access, and quality.

- **Affordability.** The latest available data show employer premiums are continuing to rise at the [low rates](#) observed since the ACA was enacted. This year, the average family premium for the more than 150 million Americans with employer coverage is \$3,600 lower than it would be if pre-ACA premium growth had continued.
- **Access.** More than 20 million American adults have gained coverage as a result of provisions of the Affordable Care Act. In addition, [more than 3 million](#) children have gained coverage since 2008, thanks in large part to the ACA and improvements to the Children’s Health Insurance Program.
- **Quality.** For those who already had coverage, the ACA provided new protections, including guaranteed limits on out-of-pocket costs, no limits on annual or lifetime coverage, and preventive services without cost sharing. The ACA is also strengthening health care quality, with large drops in patient harms and preventable [hospital readmissions](#) for Medicare beneficiaries.

“Our nation has made historic progress under the ACA, and now we want to build on that progress to further improve affordability, access, and quality,” said Secretary Burwell.

The President has taken a number of steps to improve the ACA, and thinks we can do even more, such as: expanding Medicaid in states that have declined to do so; providing more tax credits for middle-income families and young adults to further improve affordability; adding a public plan fallback to give people more options in places where there still are just not enough insurers to compete; and supporting innovation by states. But this Open Enrollment, we are focused on getting as many uninsured people covered as we can.

Open Enrollment, which starts November 1 and ends on January 31, 2017, provides another opportunity for Americans to find affordable coverage for them and their families. Learn more on HealthCare.gov. To find the ASPE **landscape issue brief**, visit: <https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2017-health-insurance-marketplace>

###

MACRA/Quality Payment Program (QPP) Updates

Learn More about the New Medicare Quality Payment Program – Upcoming Webinars

The Centers for Medicare & Medicaid Services (CMS) invites you to join webinars on **October 26 and November 15** on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) [final rule with comment period](#). The webinars will provide an overview of the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) incentive payment provisions under MACRA, collectively referred to as the Quality Payment Program.

Quality Payment Program Overview

- **Date:** Wednesday, October 26, 2016
- **Time:** 2:00 to 3:00 PM ET
- **Register:** <https://engage.vevent.com/rt/cms/index.jsp?seid=530>

Quality Payment Program Final Rule MLN Connects® Call — November 15

- **Date:** Tuesday, November 15, 2016
- **Time:** 1:30 to 3:00 PM ET
- **Register** [MLN Connects Event Registration](#).
- **Target Audience:** Medicare Part B Fee-For-Service clinicians, office managers and administrators; state and national associations that represent healthcare providers; and other stakeholders.

During these calls, participants will learn about the provisions in the recently released [final rule](#); participants should review the rule prior to the call. A question and answer session will follow the presentation.

Space for these webinars is limited. Register now to secure your spot. After you register, you will receive an email message with a dial-in number and webinar link. Please note, you will not be able to share your participant information because it will be unique to you.

For More Information

To learn more about the final rule and the Quality Payment Program, view the following resources:

- [Quality Payment Program website](#)
- [Press release](#)
- [Executive summary, fact sheet and other resources](#)
- [CMS Blog post by Acting Administrator Andy Slavitt](#)

###

CMS announces additional opportunities for clinicians to join innovative care approaches under the Quality Payment Program

Today, the Centers for Medicare & Medicaid Services (CMS) announced new opportunities for clinicians to join Advanced Alternative Payment Models (APMs) developed by the CMS Innovation Center to improve care and potentially earn an incentive payment under the Quality Payment Program created through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment

Program rewards clinicians with sufficient participation in Advanced APMs that align incentives for high-quality, patient-centered care. By giving more clinicians the opportunity to participate in these models, today's announcement will extend the benefits of high-quality, coordinated care to more Medicare beneficiaries.

“Every day, the CMS Innovation Center is improving the future of Medicare by testing innovative care models across the country,” said CMS Acting Administrator Andy Slavitt. “Now, thanks to the bipartisan MACRA, clinicians have more opportunities and motivation to join these evidence-based approaches, which aim to improve care quality while creating cost savings.”

CMS is announcing that it expects to re-open applications for new practices and payers in the Comprehensive Primary Care Plus (CPC+) model and new participants in the Next Generation Accountable Care Organization (ACO) model for the 2018 performance year. In addition, CMS is announcing that the Innovation Center's Oncology Care Model with two-sided risk will now be available in 2017, which will qualify the model as an Advanced APM beginning in the 2017 performance year.

In 2017, under the Quality Payment Program, clinicians may earn a 5 percent incentive payment through sufficient participation in the following Advanced APMs:

- Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement)
- Comprehensive ESRD Care Model (non-LDO arrangement)
- CPC+
- Medicare Shared Savings Program ACOs - Track 2
- Medicare Shared Savings Program ACOs - Track 3
- Next Generation ACO Model
- Oncology Care Model (two-sided risk arrangement)

In 2018, we anticipate that clinicians may also earn the incentive payment through sufficient participation in the following models:

- ACO Track 1+
- New voluntary bundled payment model
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology (CEHRT) track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track)

These lists will continue to change and grow as more models are proposed and developed in partnership with the clinician community and the Physician-Focused Payment Model Technical Advisory Committee.

“With these new opportunities, CMS expects that by the 2018 performance period, 25 percent of clinicians in the Quality Payment Program will earn incentive payments by being a part of these advanced models,” said Dr. Patrick Conway, Deputy Administrator of CMS. “Thanks to MACRA and the Innovation Center, we're striving to see more Medicare patients benefit from better care when they visit their doctor for a knee replacement, receive cancer treatment, or have a coordinated care team manage their complex conditions.”

For more information, please visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-25.html>

###

Medicare's Investment in Primary Care Shows Progress

The Centers for Medicare & Medicaid Services (CMS) announced the [Comprehensive Primary Care \(CPC\) initiative's](#) second round of shared savings results, with nearly all practices (95 percent) meeting quality of care requirements and four out of seven regions sharing in savings with CMS. These results reflect the work of 481 practices that served over 376,000 Medicare beneficiaries and more than 2.7 million patients overall in 2015.

As the largest test of advanced primary care in U.S. history, CPC demonstrates the potential of primary care clinicians redesigning their practices to deliver better care to their patients, and provides clinicians support to innovate and deliver care in ways that better meet their patients' needs and preferences.

During 2015, its second shared savings performance year, CPC generated a total of \$57.7 million gross savings in Part A and Part B expenditures. These savings are essentially equivalent to the \$58 million paid in care management fees to the practices. Four of the seven regions participating in CPC – the states of Arkansas, Colorado, and Oregon, and the Greater Tulsa region in Oklahoma – realized net savings (after accounting for the care management fees paid) and will share in those savings with CMS. Although three of the CPC regions had net losses, the savings generated in the other four regions covered those losses, such that care management fees across CPC were offset by reduced spending on Medicare Part A and Part B services. Further, more than half of participating CPC practices will receive a share of over \$13 million in earned shared savings.

In addition to the gross Medicare savings, CPC practices showed positive quality, with lower than expected hospital admission and readmission rates, and favorable performance on patient experience measures. CPC practices' performance on electronic Clinical Quality Measures (eCQMs) also exceeded national benchmarks, particularly on preventive health measures.

This is the first year CMS has included eCQM performance in Medicare shared savings determinations for CPC. eCQM reporting covering the entire practice population at the practice site level is critical to using health information technology as a tool to support care delivery transformation. eCQM data are recorded in the electronic health record in the routine course of clinical care, allowing practices to engage in real time quality improvement efforts that drive population health. As we move to a health care system that rewards value over volume, CPC practices are at the forefront of using eCQMs for quality improvement, measurement, and reporting.

Quality highlights from the 2015 shared savings performance year include:

- 97 percent of CPC practices successfully reported 9 eCQMs. For ten out of the eleven eCQMs in the CPC measure set, the majority of CPC practices who reported surpassed the median national performance.
- Nearly all (99 percent) practices reported higher levels of colorectal cancer screening and influenza immunization compared to national benchmarks. Additionally, 100 percent of practices who reported on screening for clinical depression surpassed national benchmarks.
- Compared to 2014, most regions maintained or improved their scores on hospital readmissions and admissions for chronic obstructive pulmonary disorder and congestive heart failure.
- Patients rated the care they receive from their CPC practitioners highly, particularly on how well practitioners supported them in taking care of their own health and the attention they paid to care from other providers.

The positive performance is a testament to the efforts CPC practices have made to provide truly “comprehensive primary care.”

CPC is a multi-payer partnership launched by the Center for Medicare and Medicaid Innovation (Innovation Center) in October 2012 to advance primary care by paying clinicians to deliver accessible, comprehensive, and coordinated care in [seven regions](#) across the country. CPC supports advanced primary care as the foundation of our health system. In addition to attending to patients' acute, chronic, and preventive health care needs, primary care practices act as the quarterback of each patient's health care team. CPC practices help patients navigate their care, communicate with specialists and hospitals, and ensure that patients with complex social and medical needs do not "fall through the cracks" of the health care system.

These results build on the first shared savings performance year in 2014. Gross savings nearly doubled from the first performance year to the second and practices in four regions were eligible to receive shared savings, compared to one region in 2014. Primary care transformation takes time, and it is especially encouraging that CPC practices maintained such positive quality of care results while also seeing gross Medicare savings in the 2015 performance year.

The experience in CPC has contributed to our continued efforts to support primary care going forward in the Innovation Center's Comprehensive Primary Care Plus (CPC+), which will begin on January 1, 2017 and for which we recently announced the 14 selected regions and are currently reviewing practice applications. CMS anticipates that CPC+ could meet the criteria to qualify as an Advanced Alternative Payment Model (Advanced APM) under the recently finalized [Quality Payment Program](#) rule, which implements the Medicare Access and CHIP Reauthorization Act of 2015. A robust primary care system is essential to achieve better care, smarter spending, and healthier people. For this reason, CMS is committed to supporting primary care clinicians to deliver the best, most comprehensive primary care possible for their patients.

###

Medicare and Medicaid Updates

Reminder: Medicare Open Enrollment Takes Place from October 15 – December 7, 2016

The Medicare Open Enrollment period, which began last week, takes place each year from October 15 through December 7. While Marketplace Assisters work primarily to help consumers enroll in coverage through HealthCare.gov, their state Marketplace, or through Medicaid/CHIP, it may be helpful to be aware that Medicare Open Enrollment is currently taking place. For example, if you are working with a family with one or more members eligible for Medicare, you should be aware that this individual will have different coverage needs. Consumers who have become eligible for Medicare may wish to cancel their Marketplace plans. For more information, [click here](#) for details on Medicare Open Enrollment, including state-by-state fact sheets.

For more information on Medicare and the Marketplace, see [this page on HealthCare.gov](#). Assisters can also [click here](#) to learn more about how to help consumers cancel their Marketplace plan once they become eligible for Medicare.

###

CMS Awards Special Innovation Projects to Quality Innovation Network-Quality Improvement Organizations Aimed to Drive Better Care, Smarter Spending, and Healthier People

The Centers for Medicare & Medicaid Services (CMS) has taken another step toward ensuring that beneficiaries receive better care, better value, and achieve better overall care, smarter spending, and healthier people by awarding 20, two-year Special Innovation Projects (SIPs) to 12 regional Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs). The SIPs offer QIN-QIOs and their partners, clinicians, schools of higher education, innovation labs, and Medicare beneficiaries and their families the opportunity to address critical health care issues important to their constituency in the areas of quality improvement that may be underutilized, but represent a significant opportunity if spread locally, regionally, or nationally. QIN-QIOs serve the Medicare population by working with Medicare beneficiaries, providers, and communities in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. QIN-QIOs were eligible to submit proposals for two types of SIPs in 2016:

1. Projects addressing issues of quality occurring within the QIN-QIOs' local service area: "Advance Local Efforts for Better Care at Lower Cost."
2. Projects focusing on expanding the scope and national impact of quality improvement interventions that have proven success in limited areas or scope: "Interventions that are Ready for Spread and Scalability."

Projects that "Advance Local Efforts for Better Care at Lower Cost" include:

- Great Plains QIN will work with 25 home health agencies in Kansas, Nebraska, North Dakota, and South Dakota to develop and test educational interventions to prevent and manage common infections observed in home health such as respiratory, urinary tract and wound infections.

- Health Services Advisory Group will be building capacity for telepsychiatry services in the Virgin Islands of St. Croix, St. John, and St. Thomas to address the lack of psychiatric specialty services available.
- TMF Quality Innovation Network will be working with 80 physician practices in Arkansas, Missouri, Oklahoma, and Texas to increase primary care physician knowledge of treatment for depression and alcohol use disorder through knowledge transfer from specialists to primary care physicians.

Topic areas for “Interventions that are Ready for Spread and Scalability” were identified through consultation with the [Strategic Innovation Engine](#) (SIE). The Strategic Innovation Engine (SIE) is a new endeavor that will advance [CMS’ six quality goals](#) by rapidly moving innovative, evidence-based quality practices from research to implementation throughout the QIN-QIO program and be made available to the greater health care community. The SIE will serve as an instrument in furthering the science of improvement to better inform quality improvement efforts in the future for QIOs and others that draws upon the literature, healthcare quality data, and experts and practitioners in the field to ensure safe, effective practices are available for use by providers seeking to improve quality and reduce costs.

These high leverage topic areas include streamlining patient flow in health care settings; working with health plans and care coordination providers on approaches to post-acute care that results in enhanced care management; increasing value, patient affordability, and appropriate use of specialty drugs by applying evidenced based criteria to prescribing practices; addressing acute pain management in sickle cell patients; and utilizing big data analytics to reduce preventable harm in health care. Examples of funded projects for “Interventions that are Ready for Spread and Scalability” include:

- Alliant Quality, utilizing the breakthrough collaborative model, will work with 30 emergency departments in Georgia and North Carolina to improve the triage, treatment, and quality of care received by patients with sickle cell disease who present to the emergency room in vaso-occlusive crisis (VOC). It is expected that interventions will result in appropriate and timely pain management and improved patient experience.
- Atlantic Quality Innovation Network, working in New York (Orange, Putnam, and Dutchess Counties) with physician offices, pharmacies, hospitals, nursing homes and county health departments, seeks to modify and standardize prescribing practices for managing anticoagulants during the periprocedural period to reduce anticoagulant adverse drug events in all patients, including Medicare Fee-for-Service beneficiaries. Interventions include the operationalization of a mobile/web-based application for clinical decision support in hospital/ambulatory surgery settings and optimization of patient education using health information technology.
- Qualis Health, working in Washington and Idaho, seeks to improve the quality, safety, and reliability of the care transition process by focusing on a comprehensive assessment of the social determinants impacting beneficiaries’ transitions from the hospital to the home and creating robust linkages to community social service providers for high-risk beneficiaries to improve care coordination and reduce avoidable medical care utilization.

CMS sought proposals with scientific rigor, a strong analytic framework and a reasonable, proposed intervention based on the supporting evidence. CMS looked for evidence of QIN-QIO partnerships at the community, regional and national levels, and inclusion of patients and families in each project as well as direct links to the CMS Quality Strategy goals.

A complete list of 2016 SIP awardees is located on the [QIO Program website](#).

We are committed to innovation and are excited to study the results produced by these SIPs and to identify ways in which to incorporate them throughout the QIO Program based upon their results. The SIPs create

an exciting opportunity for providers, professional organizations, innovation labs, and others to innovate and impact health care quality in the Medicare program at local, regional and national levels through the QIO Program.

###

Medicaid Program; Final FY 2014 and Preliminary FY 2016 Disproportionate Share Hospital Allotments, and Final FY 2014 and Preliminary FY 2016 Institutions for Mental Diseases Disproportionate Share Hospital Limits

Today the Centers for Medicare & Medicaid Services (CMS) issued a notice announcing the final federal share disproportionate share hospital (DSH) allotments for federal fiscal year (FY) 2014 and the preliminary federal share DSH allotments for FY 2016. This notice also announces the final FY 2014 and the preliminary FY 2016 limitations on aggregate DSH payments that states may make to institutions for mental disease and other mental health facilities. In addition, this notice includes background information describing the methodology for determining the amounts of states' FY DSH allotments.

Click here to view the notice at the Federal Register:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-25813.pdf> and on 10/26/2016 and available online at <https://federalregister.gov/d/2016-25813>

Also, this notice will be posted to Medicaid.gov: <https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html>

###

Time-Limited Medicare Part B Enrollment Relief for Marketplace Enrollees

Some marketplace enrollees delayed or declined Medicare Part B enrollment, only to find out later that their Medicare-eligibility made them ineligible for PTC and that Part B late enrollment penalties would apply. The Centers for Medicare & Medicaid Services (CMS) **recently established a time-limited opportunity for equitable relief for people enrolled in marketplace plans who mistakenly delayed or declined Medicare Part B because of confusion or mistakes regarding PTC or other subsidies**, even if they did not get explicit misinformation from any government entity. Equitable relief allows an individual who made a Part B enrollment error to request retroactive Part B enrollment and/or relief from the Part B late enrollment penalty from the Social Security Administration.

This opportunity is available through March 2017. Please refer consumers who may have made a Part B enrollment error to their local [State Health Insurance Assistance Program \(SHIP\)](#) or the [Medicare Rights Center](#) for assistance requesting equitable relief.

###

Tri-Dept FAQ Set 33 on Student Health Insurance Plans (SHIP)

HHS, Department of Labor and Treasury jointly released an FAQ that extends prior enforcement relief provided in Technical Release 2016-01 to colleges and universities for certain health care premium reduction arrangements offered in connection with student health coverage. Technical Release 2016-01 provided that a premium reduction arrangement does not fail to satisfy the market reform provisions of the

ACA if the arrangement is offered in connection with other student health coverage for a plan year or policy year beginning before January 1, 2017 (i.e. summer and fall plans). FAQs (PDF) are on CCIIO's website [here: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQ-Set-33-Final.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQ-Set-33-Final.pdf)

###

Information about Seamless Conversion Enrollment

The Centers for Medicare & Medicaid Services (CMS) released data identifying the plans and number of Medicare beneficiaries impacted by seamless conversion enrollment. Seamless conversion is a process that allows organizations to enroll individuals from their current healthcare coverage into a Medicare Advantage plan offered by the same organization as of the first day their Medicare coverage starts, if they do not elect to receive coverage in another way.

CMS will also be announcing through HPMS to Medicare Advantage organizations that CMS is revisiting the seamless conversion enrollment policy and is temporarily suspending its acceptance of any new seamless enrollment proposals.

For more information click here: <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html>

###

IRF and LTCH Public Reporting Update - CDC & NHSN Rebaseline Guidance

As noted in the Rebaseline Timeline posted in the [June 2016 National Healthcare Safety Network \(NHSN\) Newsletter](#), the CDC submitted standardized infection ratios (SIRs) to CMS using the new 2015 baseline starting with 2016 Q1 data. The Inpatient Rehabilitation Facility (IRF) and Long-term Care Hospital (LTCH) Quality Reporting Program (QRP) Preview Reports that CMS provided on September 1, 2016 contained calendar year (CY) 2015 healthcare-associated infection (HAI) SIRs in accordance with the new NHSN baselines based on nationally collected data from 2015. However, providers were unable to use NHSN to verify the accuracy of the HAI data contained within their preview reports for the Compare sites during the 30-day preview period established for this purpose.

Consequently, **CMS will begin publically displaying the NHSN data on the Compare sites for IRFs and LTCHs in the next quarterly refresh in spring 2017 instead of in fall 2016.** Providers will have the chance to appropriately review their HAI data and inquire about data they believe to be discrepant. IRFs and LTCHs will receive preview reports in December 2016 for the data that will be displayed in spring 2017.

This change will affect the posting of quality performance data on the following quality measures:

- NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (IRFs and LTCHs)
- NHSN Central-Line Associated Bloodstream Infections (CLABSI) Outcome Measure (LTCHs only)

When the IRF and LTCH Compare websites are launched in fall 2016, the following quality metrics will be displayed:

IRFs—

- Percent of residents or patients with pressure ulcers that are new or worsened (short stay)
- All-cause unplanned readmission measure for 30 days post-discharge from Inpatient Rehabilitation Facilities

LTCHs—

- Percent of residents or patients with pressure ulcers that are new or worsened (short stay)
- All-cause unplanned readmission measure for 30 days post-discharge from long-term care hospitals

To assist IRFs and LTCHs in understanding the use of the rebaselined data and how to monitor their data using the new baseline, a document has been posted in the downloads section of the [IRF Quality Public Reporting](#) and [LTCH Quality Public Reporting](#) webpages.

###

Medicare Learning Network

News & Announcements

- [CMS Announces New Initiative to Increase Clinician Engagement](#)
- [Medicare’s Investment in Primary Care Shows Progress](#)
- [Physician Compare Preview Period Ends November 11](#)
- [Value Modifier: Informal Review Request Period Open through November 30](#)
- [2015 Supplemental Quality and Resource Use Reports Available](#)
- [Medicare Open Enrollment Information for your Patients](#)

Provider Compliance

- [Importance of Documentation](#)

Claims, Pricers & Codes

- [October 2016 OPPS Pricer File Update](#)

Upcoming Events

- [Long-Term Care Facilities: Reform of Requirements Call — October 27](#)
- [How to Report Across 2016 Medicare Quality Programs Call — November 1](#)
- [Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2](#)
- [Quality Payment Program Final Rule Call — November 15](#)
- [Home Health Quality Reporting Program Provider Training — November 16 and 17](#)

Medicare Learning Network® Publications & Multimedia

- [Provider Compliance Fact Sheets — New](#)
- [Emergency Preparedness Requirements Call: Audio Recording and Transcript — New](#)
- [Evaluation and Management Services Guide — Revised](#)
- [Hospice Payment System Booklet — Revised](#)
- [Provider Compliance Fact Sheets — Revised](#)
- [Continuing Education Credits for Web-Based Training Courses](#)

###

Time again to check your Medicare health and drug plans - Iowa

Now's the time for Iowans with Medicare to check their health and drug coverage for 2017. Medicare's open enrollment period runs from October 15, until December 7.

Open enrollment is the best time to make sure your health and drug plans still meet your individual needs, especially if you've had any changes in your health. By now insurers should have notified you of any adjustments in your health or drug coverage or any changes in your out-of-pocket costs for next year.

The average monthly premium for a Medicare Advantage plan will drop by \$1.19 to \$31.40, while the average monthly premium for a basic drug plan will inch up \$1.50 to \$34. Medicare Advantage remains a strong alternative for people who prefer to receive care through a private insurer rather than through Medicare's original fee-for-service program.

Enrollment in the private Medicare Advantage plans is expected to grow by 1.2 million to 18.5 million people in 2017 – about 32 percent of Medicare beneficiaries. Even if you've been satisfied with your health and drug coverage, you may benefit from reviewing all your options. Shopping around may save you money or improve your coverage.

Iowans in Medicare's original fee-for-service program can choose from 22 drug plans with the lowest monthly premium at \$17.00. Look beyond premiums, though. The only way to determine the true cost of your drug coverage is to consider other factors like deductibles, co-payments and coinsurance.

Medicare's website – www.medicare.gov – has the best tool for helping you narrow your search for a new health or drug plan. Just click on “Find Health and Drug Plans.”

After entering your ZIP code and the list of your prescriptions, you can use the “Medicare Plan Finder” tool to compare your coverage and out-of-pocket costs under different plans. The quality of a health or drug plan's customer service should be considered, too. To help you identify the best and worst, the Plan Finder provides star ratings for each plan. A gold star will show plans with the highest, five-star rating, while a warning icon will alert you to plans that have performed poorly for at least the past three years.

Besides using Medicare.gov, you can call Medicare's toll-free help line at 1-800-633-4227 or consult your “Medicare & You 2017 Handbook,” which you have just received in the mail. **One-on-one benefits counseling is also available through your State Health Insurance Assistance Program for free. In Iowa, you should call 1-800-351-4664.**

Thanks to the health care law, you'll enjoy more savings on your prescriptions in 2017 once you land in the coverage gap, known as the “doughnut hole.” You'll receive a 60 percent discount on your brand-name drugs and a 49 percent discount on your generic drugs while in the gap. The doughnut hole begins once you and your drug plan have spent \$3,700 for your drugs. If you're having difficulty affording your medications, you may qualify for extra help with your drug coverage premiums, deductibles and co-payments. The amount of help depends on your income and resources. But, generally, you'll pay no more than \$3.30 for generic drugs and \$8.25 for brand-name drugs. 22 percent of Iowans with Medicare's drug coverage now get such a break. To learn more about whether you qualify for extra help, visit www.socialsecurity.gov/prescriptionhelp or call Social Security at 1-800-772-1213.

There's no better time to check your Medicare coverage. Any changes you make will take effect on January, 1.

###

Time again to check your Medicare health and drug plans - Kansas

Now's the time for Kansans with Medicare to check their health and drug coverage for 2017. Medicare's open enrollment period runs from October 15, until December 7.

Open enrollment is the best time to make sure your health and drug plans still meet your individual needs, especially if you've had any changes in your health. By now insurers should have notified you of any adjustments in your health or drug coverage or any changes in your out-of-pocket costs for next year.

The average monthly premium for a Medicare Advantage plan will drop by \$1.19 to \$31.40, while the average monthly premium for a basic drug plan will inch up \$1.50 to \$34.

Medicare Advantage remains a strong alternative for people who prefer to receive care through a private insurer rather than through Medicare's original fee-for-service program.

Enrollment in the private Medicare Advantage plans is expected to grow by 1.2 million to 18.5 million people in 2017 – about 32 percent of Medicare beneficiaries. Even if you've been satisfied with your health and drug coverage, you may benefit from reviewing all your options. Shopping around may save you money or improve your coverage.

Kansans in Medicare's original fee-for-service program can choose from 22 drug plans with the lowest monthly premium at \$17.00. Look beyond premiums, though. The only way to determine the true cost of your drug coverage is to consider other factors like deductibles, co-payments and coinsurance.

Medicare's website – www.medicare.gov – has the best tool for helping you narrow your search for a new health or drug plan. Just click on "Find Health and Drug Plans." After entering your ZIP code and the list of your prescriptions, you can use the "Medicare Plan Finder" tool to compare your coverage and out-of-pocket costs under different plans. The quality of a health or drug plan's customer service should be considered, too. To help you identify the best and worst, the Plan Finder provides star ratings for each plan. A gold star will show plans with the highest, five-star rating, while a warning icon will alert you to plans that have performed poorly for at least the past three years.

Besides using Medicare.gov, you can call Medicare's toll-free help line at 1-800-633-4227 or consult your "Medicare & You 2017 Handbook," which you have just received in the mail. **One-on-one benefits counseling is also available through your State Health Insurance Assistance Program for free. In Kansas, you should call 1-800-860-5260.**

Thanks to the health care law, you'll enjoy more savings on your prescriptions in 2017 once you land in the coverage gap, known as the "doughnut hole." You'll receive a 60 percent discount on your brand-name drugs and a 49 percent discount on your generic drugs while in the gap. The doughnut hole begins once you and your drug plan have spent \$3,700 for your drugs. If you're having difficulty affording your medications, you may qualify for extra help with your drug coverage premiums, deductibles and co-payments. The amount of help depends on your income and resources. But, generally, you'll pay no more than \$3.30 for generic drugs and \$8.25 for brand-name drugs. 24 percent of Kansans with Medicare's drug coverage now get such a break. To learn more about whether you qualify for extra help, visit www.socialsecurity.gov/prescriptionhelp or call Social Security at 1-800-772-1213.

There's no better time to check your Medicare coverage. Any changes you make will take effect on January, 1.

###

Time again to check your Medicare health and drug plans - Missouri

Now's the time for Missourians with Medicare to check their health and drug coverage for 2017. Medicare's open enrollment period runs from October 15, until December 7.

Open enrollment is the best time to make sure your health and drug plans still meet your individual needs, especially if you've had any changes in your health. By now insurers should have notified you of any adjustments in your health or drug coverage or any changes in your out-of-pocket costs for next year.

The average monthly premium for a Medicare Advantage plan will drop by \$1.19 to \$31.40, while the average monthly premium for a basic drug plan will inch up \$1.50 to \$34.

Medicare Advantage remains a strong alternative for people who prefer to receive care through a private insurer rather than through Medicare's original fee-for-service program.

Enrollment in the private Medicare Advantage plans is expected to grow by 1.2 million to 18.5 million people in 2017 – about 32 percent of Medicare beneficiaries. Even if you've been satisfied with your health and drug coverage, you may benefit from reviewing all your options. Shopping around may save you money or improve your coverage.

Missourians in Medicare's original fee-for-service program can choose from 23 drug plans with the lowest monthly premium at \$17.00. Look beyond premiums, though. The only way to determine the true cost of your drug coverage is to consider other factors like deductibles, co-payments and coinsurance.

Medicare's website – www.medicare.gov – has the best tool for helping you narrow your search for a new health or drug plan. Just click on "Find Health and Drug Plans." After entering your ZIP code and the list of your prescriptions, you can use the "Medicare Plan Finder" tool to compare your coverage and out-of-pocket costs under different plans.

The quality of a health or drug plan's customer service should be considered, too. To help you identify the best and worst, the Plan Finder provides star ratings for each plan. A gold star will show plans with the highest, five-star rating, while a warning icon will alert you to plans that have performed poorly for at least the past three years.

Besides using Medicare.gov, you can call Medicare's toll-free help line at 1-800-633-4227 or consult your "Medicare & You 2017 Handbook," which you have just received in the mail. One-on-one benefits counseling is also available through your State Health Insurance Assistance Program for free. In Missouri, you should call 1-800-390-3330.

Thanks to the health care law, you'll enjoy more savings on your prescriptions in 2017 once you land in the coverage gap, known as the "doughnut hole." You'll receive a 60 percent discount on your brand-name drugs and a 49 percent discount on your generic drugs while in the gap. The doughnut hole begins once you and your drug plan have spent \$3,700 for your drugs. If you're having difficulty affording your medications, you may qualify for extra help with your drug coverage premiums, deductibles and co-payments. The amount of help depends on your income and resources. But, generally, you'll pay no more than \$3.30 for generic drugs and \$8.25 for brand-name drugs. 28 percent of Missourians with Medicare's drug coverage now get such a break.

To learn more about whether you qualify for extra help, visit www.socialsecurity.gov/prescriptionhelp or call Social Security at 1-800-772-1213.

There's no better time to check your Medicare coverage. Any changes you make will take effect on January, 1.

###

Time again to check your Medicare health and drug plans - Nebraska

Now's the time for Nebraskans with Medicare to check their health and drug coverage for 2017. Medicare's open enrollment period runs from October 15, until December 7.

Open enrollment is the best time to make sure your health and drug plans still meet your individual needs, especially if you've had any changes in your health. By now insurers should have notified you of any adjustments in your health or drug coverage or any changes in your out-of-pocket costs for next year. The average monthly premium for a Medicare Advantage plan will drop by \$1.19 to \$31.40, while the average monthly premium for a basic drug plan will inch up \$1.50 to \$34.

Medicare Advantage remains a strong alternative for people who prefer to receive care through a private insurer rather than through Medicare's original fee-for-service program. Enrollment in the private Medicare Advantage plans is expected to grow by 1.2 million to 18.5 million people in 2017 – about 32 percent of Medicare beneficiaries. Even if you've been satisfied with your health and drug coverage, you may benefit from reviewing all your options. Shopping around may save you money or improve your coverage.

Nebraskans in Medicare's original fee-for-service program can choose from 22 drug plans with the lowest monthly premium at \$17.00. Look beyond premiums, though. The only way to determine the true cost of your drug coverage is to consider other factors like deductibles, co-payments and coinsurance.

Medicare's website – www.medicare.gov – has the best tool for helping you narrow your search for a new health or drug plan. Just click on "Find Health and Drug Plans." After entering your ZIP code and the list of your prescriptions, you can use the "Medicare Plan Finder" tool to compare your coverage and out-of-pocket costs under different plans.

The quality of a health or drug plan's customer service should be considered, too. To help you identify the best and worst, the Plan Finder provides star ratings for each plan. A gold star will show plans with the highest, five-star rating, while a warning icon will alert you to plans that have performed poorly for at least the past three years.

Besides using Medicare.gov, you can call Medicare's toll-free help line at 1-800-633-4227 or consult your "Medicare & You 2017 Handbook," which you have just received in the mail. **One-on-one benefits counseling is also available through your State Health Insurance Assistance Program for free. In Nebraska, you should call 1-800-234-7119.**

Thanks to the health care law, you'll enjoy more savings on your prescriptions in 2017 once you land in the coverage gap, known as the "doughnut hole." You'll receive a 60 percent discount on your brand-name drugs and a 49 percent discount on your generic drugs while in the gap. The doughnut hole begins once you and your drug plan have spent \$3,700 for your drugs. If you're having difficulty affording your medications, you may qualify for extra help with your drug coverage premiums, deductibles and co-

payments. The amount of help depends on your income and resources. But, generally, you'll pay no more than \$3.30 for generic drugs and \$8.25 for brand-name drugs. 23 percent of Nebraskans with Medicare's drug coverage now get such a break.

To learn more about whether you qualify for extra help, visit www.socialsecurity.gov/prescriptionhelp or call Social Security at 1-800-772-1213.

There's no better time to check your Medicare coverage. Any changes you make will take effect on January, 1.

###

Fight Fraud by Guarding Your Medicare Number

Health care fraud drives up costs for everyone in the health care system. One way to protect against such fraud is to **guard your Medicare number**. Fraud schemes often depend on identity thieves getting hold of people's Medicare numbers, so treat your number as you would a credit card.

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.
- 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.
- 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 items 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" – especially if you need to hand over your Medicare number in order to receive these items or deals. Decline politely but firmly.
- By law, 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.

Translations of the Fraud Prevention Campaign drop-in article are also available in 8 languages including Spanish, Russian, Chinese, Vietnamese, Korean, Armenian, and Tagalog.

Call 1-800-MEDICARE to report suspected fraud. Learn more about protecting yourself from health care fraud by visiting www.Medicare.gov/fraud 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.

This information prepared by the U.S. Department of Health and Human Services.

###

Hospital Compare is Updated with VA Hospital Performance Data

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the inclusion of Veterans Administration (VA) hospital performance data. The VA hospital performance data can be found via a link on *Hospital Compare*: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html>. Additional VA hospital data will be added in December with plans for future seamless integration of VA data onto the *Hospital Compare* website to allow comparison of performance between VA and civilian acute care hospitals.

“We are excited to be working with VA to expand on this work so that Americans will have the information they need on more facilities in order to make an informed decision on their health care,” said Patrick Conway, M.D., CMS Acting Principal Deputy Administrator and Chief Medical Officer. “We are strongly committed to transparency and providing Americans seeking health care information they need to help make decisions on the care they seek.”

The VA tables include data for quarterly timely and effective care measures, VA satisfaction survey results, outcomes measures including mortality and readmission rates for selected conditions, behavioral health measures, and measures of patient safety.

The goal of this project is to present the VA’s quality and safety data to veterans, their families and the public in a useful and understandable format.

“We are so pleased to be reporting our facility quality and safety data for sharing via Medicare’s website,” said Dr. Carolyn Clancy, Deputy Under Secretary for Health for Organizational Excellence, Veterans Health Administration. “CMS has the world’s most trusted reporting system for hospital performance. VA’s participation in this is a good value for veterans and for the nation.”

###

Upcoming Webinars and Events and Other Updates

Long-Term Care Facilities: Reform of Requirements Call — October 27

Thursday, October 27 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects® Event Registration](#). Space may be limited, register early.

During this call, learn about the [final rule](#) to reform the requirements for long-term care facilities. These requirements are the federal health and safety standards that long-term care facilities must meet in order to participate in the Medicare or Medicaid programs. Find out about the changes included in the final rule; implementation and survey process; and provider training and resources. A question and answer session will follow the presentation.

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

###

How to Report Across 2016 Medicare Quality Programs Call — November 1

Tuesday, November 1 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

Learn how to report quality measures during the 2016 program year to maximize your participation in Medicare quality programs, including the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, Value-Based Payment Modifier (Value Modifier), and the Medicare Shared Savings Program. Satisfactory reporters will avoid the 2018 PQRS negative payment adjustment, satisfy the clinical quality measure component of the EHR Incentive Program, and satisfy requirements for the Value Modifier to avoid the downward payment adjustment. A question and answer session will follow the presentation.

Agenda:

How to Report Across 2016 Medicare Quality Programs for:

- Individual Eligible Professionals (EPs)
- PQRS group practices
- Medicare Shared Savings Program Accountable Care Organizations (ACOs)
- Pioneer and Next Generation ACOs

Target Audience: Physicians, individual EPs, group practices, Comprehensive Primary Care practice sites, Accountable Care Organizations, therapists, practice managers, medical and specialty societies, payers, and insurers.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the [call detail page](#) for more information.

###

Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2

Wednesday, November 2 from 2:30 to 3:30 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this call, learn how to report data required by the Clinical Diagnostic Test Payment System [final rule](#). Laboratories, including physician office laboratories, are required to report HCPCS laboratory codes, associated private payor rates, and volume data if they:

- Have more than \$12,500 in Medicare revenues from laboratory services on the Clinical Laboratory Fee Schedule and
- receive more than 50 percent of their Medicare revenues from laboratory and physician services during a data collection period

CMS will use this data to set Medicare payment rates effective January 1, 2018. For more information, visit the [PAMA Regulations](#) webpage.

Agenda:

- System registration
- System demonstration: Data submission and data certification
- Question and answer session

Target Audience: Clinical diagnostic laboratory industry.

###

Home Health Quality Reporting Program Provider Training — November 16 and 17

CMS is hosting a 2-day training event for the Home Health (HH) Quality Reporting Program (QRP) in Dallas, Texas. Find out about assessment-based data collection instructions and updates associated with the changes in the January 1, 2017, release of the Outcome and Assessment Information Set (OASIS) C2 and other reporting requirements of the HH QRP. Visit the [HH QRP Training](#) webpage for more information and to register.

###

Special Open Door Forum: Home Oxygen Electronic Clinical Templates

October 26, 2016 3:00-4:00 pm Eastern Time Conference Call Only

PCG will host a Special Open Door Forum (ODF) to allow physicians, provider and supplier professional associations, and/or all other interested parties to provide feedback on the Home Oxygen Electronic Clinical Templates that are posted on the CMS.gov website. The suggested templates describe the data elements that CMS believes would be useful in supporting the documentation requirements for coverage of home oxygen as follows:

1. Order,
2. Face-to-face encounter, and
3. Oxygen lab results.

The Home Oxygen Electronic Clinical Templates are available on the CMS.gov website which can be accessed through the link below: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Electronic-Clinical-Templates/Home_Oxygen_Templates.html. The suggested clinical elements are not a form, but a tool which the physician or treating practitioner may voluntarily use to create electronic medical documentation. Once completed by the physician or other practitioner, the resulting order, face-to-face encounter note and oxygen lab result templates would be part of the medical record. In addition to developing electronic data-entry templates, CMS is also developing paper versions of these templates as well.

In fiscal year (FY) 2015, the Comprehensive Error Rate Testing (CERT) program reported an improper payment rate of 48.5 percent for home oxygen claims. Of the CERT-reviewed claim lines in error, approximately 86.2 percent were found to have errors related to insufficient documentation with a majority of these errors resulting from a lack of documentation in medical records to justify Medicare coverage. The total projected improper payments for these claims was over 541 million dollars.

To better assist physicians in medical record documentation, for Medicare Fee for Service purposes, CMS has developed lists of clinical elements within a suggested electronic template. This development will allow electronic health record (EHR) vendors to create prompts to assist the practitioner when documenting. These three (3) Home Oxygen Clinical Templates are only the first of many on the list of topics that CMS is currently working to address. The current list can be found on CMS.gov by searching, "Electronic Clinical Templates".

Feedback and questions on our drafts can be sent to: HomeOxygenTemplates@cms.hhs.gov. We look forward to your participation.

Special Open Door Participation Instructions: Participant Dial-In Number: 1-(800)-837-1935

Conference ID: 87665883

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

###

Get ready for OE4 with Enroll America and HHS

With open enrollment just around the corner, we'd like to invite you to [join an important new webinar](#) we're hosting along with the Department of Health and Human Services (HHS), covering all you need to know to ensure you're ready for OE4.

This coming [Wednesday, October 26, 2016, at 2 p.m. ET](#), learn how you can plug into broader efforts to share critical health information and spread the "Get Covered, Stay Covered" message in your communities.

We'll be highlighting specific resources -- from our suite of Get Covered digital tools, to social media toolkits, to tips for engaging young Americans and organizing on campus -- that you can start using immediately.

We're just weeks away from open enrollment -- [RSVP now to Get Ready for OE4](#)

###

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

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

###

Assister Summit (Save the Date)

June 28 and 29, 2017

CMS Headquarters in Baltimore, MD

###

Learn More about the New Medicare Quality Payment Program – Upcoming Webinars

The Centers for Medicare & Medicaid Services (CMS) invites you to join webinars on **October 26 and November 15** on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) [final rule with comment period](#). The webinars will provide an overview of the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) incentive payment provisions under MACRA, collectively referred to as the Quality Payment Program.

Quality Payment Program Overview

- **Date:** Wednesday, October 26, 2016
- **Time:** 2:00 to 3:00 PM ET
- **Register:** <https://engage.vevent.com/rt/cms/index.jsp?seid=530>

Quality Payment Program Final Rule MLN Connects® Call — November 15

- **Date:** Tuesday, November 15, 2016
- **Time:** 1:30 to 3:00 PM ET

- **Register** [MLN Connects Event Registration](#).
- **Target Audience:** Medicare Part B Fee-For-Service clinicians, office managers and administrators; state and national associations that represent healthcare providers; and other stakeholders.

During these calls, participants will learn about the provisions in the recently released [final rule](#); participants should review the rule prior to the call. A question and answer session will follow the presentation.

Space for these webinars is limited. Register now to secure your spot. After you register, you will receive an email message with a dial-in number and webinar link. Please note, you will not be able to share your participant information because it will be unique to you.

For More Information

To learn more about the final rule and the Quality Payment Program, view the following resources:

- [Quality Payment Program website](#)
- [Press release](#)
- [Executive summary, fact sheet and other resources](#)
- [CMS Blog post by Acting Administrator Andy Slavitt](#)

###

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>

###

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. Answers to all questions (Q & A) will be available on the [MFHC website](#).

###

The Connecting Kids to Coverage National Campaign: Promoting Medicaid and CHIP during Marketplace Open Enrollment

October 26 from 2:00 - 3:15 p.m. EDT [Register Here](#)

The 2017 Health Insurance Marketplace Open Enrollment season runs from November 1, 2016 to January 31, 2017, and it is an important time of the year to enroll uninsured families. While Medicaid and Children's Health Insurance Program (CHIP) enrollment is open year-round, families may learn about their eligibility in these programs at this time when attention to health coverage is higher. Having information about Medicaid and CHIP at the ready while conducting Marketplace outreach can connect eligible, but unenrolled children who need healthcare coverage, to vital services.

###

Toolkits and Resources to Prepare for Open Enrollment in the Health Insurance Marketplace

November 3 at 2:00 pm EDT [Register Here](#)

To join by phone only, dial: 1 (914) 614-3221, Access Code: 401-646-726, and the pound sign (#)

Open enrollment in the Health Insurance Marketplace opened on November 1. Toolkits are available to help faith and community leaders share information on how to sign up for health insurance, why to buy health insurance and where to find local help. This complex information will be shared in a simple and understandable format. A question and answer session will take place at the end of the webinar. This webinar is sponsored by the Centers for Medicare and Medicaid Services (CMS).

###

Grant Opportunities

AWARD: Community Economic Development

Description: CED programs will allow local, nonprofit and community-development corporations to apply for up to \$800,000 for commercial and retail opportunities and equity investments. Companies can also use the funding to apply for loans to start a new business or expand a current business. [Read More](#)

Grant Administered by: Administration for Children and Families

AWARD: Healthy Food Financing Initiative

Description: These grants enable local, nonprofit and community development corporations to apply for grant funding for up to \$800,000 to improve access to healthy food and reduce food deserts. Awardees use the funding to develop businesses, such as grocery stores, farmers markets and food-distribution businesses that increase access to healthy food options, especially in places where access to healthy options is otherwise scarce. [Read More](#)

Grant Administered by: Administration for Children and Families

###

2016 Health Insurance Marketplace Training: Health Insurance Marketplaces: Information for Immigrant Families November 9, 2016 2:00 – 3:00 pm ET

This webinar will provide information about Health Insurance Marketplaces and eligibility based on immigration status. Topics will include

- Marketplace Eligibility & Enrollment
- Eligible Immigration Statuses and Documentation
- Marketplace Affordability
- Resources

To join the webinar, visit <https://goto.webcasts.com/starthere.jsp?ei=1110444>.

###

Complex Eligibility Scenarios

Thursday, November 10, 2016 | 2:00 – 3:00 pm ET (11:00 am – 12:00 pm PT)

[Register now](#)

Preventing & Resolving Data-Matching Issues

Thursday, November 17, 2016 | 2:00 – 3:00 pm ET (11:00 am – 12:00 pm PT)

[Register now](#)

For more information on any of these upcoming webinars, please see our [Upcoming Webinars](#) page. If you are unable to participate in any of the webinars, a video recording of each webinar will be posted to our [Health Reform: Beyond the Basics website](#). Our four-part webinar series on key elements of eligibility and enrollment, as well as additional resources, are all available on that site.

###

CMS National Training Program Monthly Partner Update Webinar November 1, 2016 2:30 – 3:30 pm ET

This webinar will feature presentations on:

- Enhancements to Dialysis Facility Compare
- Social Security Number Removal Initiative (SSNRI)

Registration is Required to Attend

Go to <https://meetings-cms.webex.com/meetings-cms/k2/j.php?MTID=t9492899f8951939404979852406a6c4c> and register.

Upon registration, you will receive an email from “messenger@webex.com” with the dial in information and webinar link. Follow the instructions in the email to attend.

###

ACA Check-up: What's the Prognosis for the Exchanges?

October 26, 2016 1:00-2:30 PM ET

Featuring:

Loren Adler
The Brookings Institution
Calvin Anderson
BlueCross BlueShield of Tennessee
Erica Coe
McKinsey & Company
Michael J. Considine & Ed Lara
Horizon Blue Cross Blue Shield of New Jersey
Kevin Counihan
CMS
Jon Urbanek & Prakash Patel
Florida Blue

Register Now

There's a growing sense of uncertainty about the future of the ACA's insurance exchanges. While 12 million people received coverage through the exchanges this year, most of them with subsidies, the upcoming open enrollment period has brought a wave of news stories highlighting each new rate increase or insurer exiting a market. This [webinar](#) will take a balanced look at what's really happening in the exchange markets and what changes are necessary to ensure consumer choice and affordability.

Topics to be discussed include:

- What to expect for the next open enrollment cycle, from prices and carrier participation to the factors influencing consumer choices
- Evidence that the ACA has actually lowered premiums and why
- Insurer experiences in different markets, including outreach strategies that have worked and what's behind rate increases
- What CMS is doing to try to strengthen the exchanges, as well as a proposal for modifying the risk adjustment program

A draft agenda is available on our [website](#).

###

Invitation from The White House (Yes, that White House)

You are invited to join a conference call on Thursday, October 27th at 3:30 PM CT with President Barack Obama and U.S. Department of Health and Human Services Secretary Sylvia M. Burwell to discuss the upcoming open enrollment period for the Health Insurance Marketplaces under the Affordable Care Act. We encourage you to circulate this invitation to friends, family, and community members who will engage in enrollment efforts during the open enrollment period from November 1st to January 31st. This call is off the record and not for press purposes. We look forward to speaking with you on Thursday!

Here are the details:

- **Date:** Thursday, October 27th
- **Time:** 3:30 PM CT, but please join 5-7 minutes early to avoid connection delays

- **RSVP:** [To receive the dial-in information, click here.](#) Once you RSVP, a dial-in, participant code, and individual pin will be provided to you via e-mail.

###

Funding opportunity, rural, opioid use and HIV prevention/engagement HIV, HCV and Related Comorbidities in Rural Communities Affected by Opioid Injection Drug Epidemics in the United States: Building Systems for Prevention, Treatment and Control (UG3/UH3)

See the links below:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-DA-17-014.html>

<http://grants.nih.gov/grants/guide/rfa-files/RFA-DA-17-023.html>

Funds Available and Anticipated Number of Awards

NIDA and partner components and agencies intend to commit an estimated total of \$6.5 Million in FY2017 to fund 8-10 UG3 awards. Future year amounts will depend on annual appropriations and successful completion of UG3 study benchmarks that permit continuation to the UH3 award. It is anticipated that 6-8 UH3 awards will be funded.

Award Budget

Application budgets for UG3 projects must not exceed \$400,000 in direct costs for any year of the project. Application budgets for UH3 projects are not limited but need to reflect the actual needs of the proposed project.

Award Project Period

The maximum project period is 5 years: up to 2 years for the first phase (UG3) and up to 3 years for the second phase (UH3).

Yvonne Walker

Guide Liaison and GPS Coordinator

Office of Extramural Policy and Review

NIDA/NIH/DHHS

6001 Executive Blvd

Bethesda, MD 20852 (for express/courier service)

Phone: 301.827.5848

Fax: 301.443.0538

Participating Organization(s)

National Institutes of Health (NIH)

Centers for Disease Control and Prevention (CDC)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Appalachian Regional Commission (ARC)

Components of Participating Organizations

National Institute on Drug Abuse (NIDA)

National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP/CDC)

Center for Substance Abuse Treatment (CSAT/SAMHSA)

Part 2. Full Text of Announcement

Section I. Funding Opportunity Description

Background

Many rural communities have experienced dramatic increases in prescription drug use that have led to increases in injection drug use, opioid overdose, and incidence of acute HCV, as well as potential for localized HIV and HCV outbreaks similar to the 2015 outbreaks in Scott County, Indiana. Rising overdose deaths and substance abuse treatment rates indicate sharp increases in opioid use, including injection use in rural areas, such as Appalachia, the Southwest US, as well as other areas across the country. The demographic profile of rural people who inject drugs (PWID) differs from PWID involved in previous urban HIV and HCV epidemics; i.e., rural PWID include higher percentages of non-Hispanic whites under 30 years of age.

Rural communities face challenges in implementing services to prevent and control substance abuse, HIV and hepatitis C virus (HCV) infections and co-morbid conditions including hepatitis B virus (HBV) infection and sexually transmitted diseases (STDs). Access to public health services including HIV, HCV, HBV or STD testing and treatment are limited. These areas have low population densities and are often located far away from concentrations of health care services for drug treatment, infectious disease management, and syringe services programs (SSPs) (where permitted by law). Rural areas often lack public transport links to metropolitan areas with well-developed services, and motor vehicle ownership often is relatively low, despite the need for private transportation. Stigma and confidentiality in small communities pose additional challenges to establishing and maintaining those services. State-level public health surveillance systems often have difficulty detecting infectious disease outbreaks in rural areas and may lack field staff experienced with rural PWID networks.

High rates of medical use of prescription opioids often have led to high rates of non-medical use of prescription opioids in rural areas; and high rates of non-medical use of prescription opioids often lead to high rates of opioid addiction, injection drug use, and unmet needs for substance abuse services in these communities.

State and local laws and law enforcement policies often limit the local availability of some services, with some exceptions that enable the delivery of more services in response to local conditions. The US Department of Health and Human Services recently released guidance to enable state and local authorities to re-direct federal assistance for syringe service programs: <https://www.aids.gov/pdf/hhs-ssp-guidance.pdf>.
Purpose

This FOA will support biphasic, i.e., two-stage, multi-method research projects that inform community response and promote comprehensive, integrated approaches to prevent HIV and HCV infection along with associated comorbidities, such as HBV infection and STDs, among people who inject drugs (PWID) in rural US communities. Opioid injection and its consequences (e.g., HIV, HCV, HBV, STDs and overdose) are the primary foci here. These projects should yield evidence of the effectiveness of community response models and best practices in responding to opioid injection epidemics that can be implemented by public health systems in similar rural communities in the US.

Applicants are encouraged to visit the Frequently Asked Questions site for more information at <https://www.drugabuse.gov/supplemental-information-nida-rfas-da-17-014-da-17-023>

The joint Funding Opportunity Announcement (FOA) will use the UG3/UH3 Cooperative Agreement mechanism to accomplish the required activities for the awards. The UG3/UH3 Cooperative Agreement mechanism involves two phases (UG3 = Phase I Exploratory-Developmental Cooperative Agreement; UH3 = Phase II Exploratory-Developmental Cooperative Agreement). The UG3 phase supports a project with

specific milestones to be accomplished by the end of the first 2-year budget period. The UH3 phase is to provide funding for up to 3 additional years to those projects that successfully completed the milestones set forth in the UG3 phase. UG3 projects that have met their milestones will be administratively considered by NIH/NIDA and CDC/NCHHSTP and prioritized for transition to the UH3 phase. Investigators responding to this FOA must address both UG3 and UH3 phases in their application.

All projects must include a Go/No-Go Transition Milestone to be assessed at the end of the UG3 phase. Funding of the UG3 (Phase 1) does not guarantee support of the UH3 (Phase 2) award for research implementation, and it is anticipated that not all funded UG3 projects will transition to the UH3 phase. Transition to the UH3 phase will be determined by a programmatic evaluation by NIH/NIDA and CDC/NCHHSTP that is based on Go/No-Go Transition Milestone accomplishment as outlined below. Continued programmatic priorities and availability of funds also affect the decision to transition to the UH3 award. Appeals of the transition decision will not be accepted.

Specific Topics of Research Interest

Projects to be funded in multiple sites by this FOA will have an initial phase, funded for two years under the UG3 mechanism, which will include epidemiologic and policy assessment, followed by formulation of local plans for new or modified services in response to these assessments, including plans for implementation and evaluation. The assessments of local epidemiology should address drug use and its infectious disease consequences (e.g., HIV, HCV, HBV, and STDs), and other adverse health consequences (e.g., overdose), as well as assessment of local infrastructure and policy that may facilitate or inhibit program and service improvements. Typical infrastructure includes public health testing facilities, community health centers including federally qualified health centers, HIV prevention and Ryan White planning groups, and HIV prevention and treatment services supported through these mechanisms, drug use coalitions, and drug treatment facilities. Although opioid injection is the primary focus, injection of other substances and non-injection substance use among PWID should be addressed.

Multi-method projects are expected with a clear plan for integrating approaches such as analysis of PWID networks, epidemiologic surveys, laboratory analyses, document reviews, ethnographic methods, program data surveys, and collection of biologic specimens. These assessments are expected to engage stakeholders and provide foundations for optimized community-based programming to facilitate: linkage to prevention services, including SSPs (unless prohibited by law) and treatment for substance abuse; testing, care, and treatment for HIV, HCV, and HBV; detection and management of STDs; and improving surveillance to detect outbreaks. Programming to prevent new opioid use, prevent transitions to injection, and prevent overdose, also should be included. Consideration should be given to improving the quality and speed of screening and diagnostic testing for blood-borne pathogens including HIV, HCV, HBV and STDs. In short, the UG3 should provide data that can identify and address steps necessary to fill gaps in the local public health and health care systems to mitigate existing injection epidemics and prevent new ones.

The new or modified programming and the data collected to inform policy that result from the UG3 phase will be the subject of the UH3 phase of the Community Response Projects and will be supported for a maximum of three years. These projects should propose an integrated model of service delivery and include a plan for evaluating the initial efficacy of this model with particular attention to evaluation of outcomes for interventions that fill gap areas. The plan also should address factors related to successful implementation and sustainability. There should be an estimate of the PWID population to be served and scientific justification for the study aims to be undertaken.

Efforts are encouraged to identify innovative service delivery approaches such as telehealth, justice system-based programs, integration with existing clinical infrastructure, or the use of non-traditional service delivery venues. Novel approaches to service financing are encouraged, including braiding of funding

streams and incorporation of public and third-party insurance, particularly where Medicaid expansion has occurred. Collaborations with state and/or local health departments are considered to be a key factor for the successful community engagement of appropriate implementing partners, as well as for strengthening and developing local data collection systems that will sustain monitoring and response to future drug use and injection epidemics and their infectious disease consequences. Although the primary focus is on services that prevent HIV, HCV, and other consequences of opioid injection, approaches are encouraged that incorporate efforts to address structural factors which may influence drug use in these communities.

The UG3 and UH3 projects should reflect the demographic composition of local opioid injection epidemics. These epidemics have been characterized by younger individuals than in past urban opioid injection epidemics, but this may vary by locality. There is also particular concern about minors and young adults because of the chronic, relapsing nature of opioid misuse and injection and the long-term effects of these conditions on physical, psychosocial and neurocognitive development. These epidemics especially have been characterized by affecting young, non-Hispanic white and rural PWIDs who have transitioned from use of prescription oral opioids to heroin and other opioid injection. Recruitment is encouraged to include minors (those under the age of 18 years), as appropriate, as well as representation of all genders, sexual minorities, and racial/ethnic minorities. The local epidemics that are the focus of the UG3/UH3 projects may have social, sexual, or drug use network connections to other HIV-infected populations (e.g., gay men or sex workers) or to HIV or HCV epidemics in nearby communities---these may warrant examination in these UG3/UH3 projects (e.g., analysis of partner patterns) but these should not become the primary focus of the UG3/UH3 projects.

Only domestic projects taking place in the United States will be supported. Applications must target communities at greatest risk of adverse events related to opioid abuse (e.g., HIV or HCV transmission, opioid overdose deaths). Resources that may be helpful in identifying areas with documented evidence of significant opioid-related HIV risk include: (1) CDC data on overdose deaths: <http://www.cdc.gov/drugoverdose/data/statedeaths.html>; (2) data sources outlined in the Department of Health and Human Services Implementation

Guidance to Support Certain Components of Syringe Services Programs, 2016 (Appendix 1, Section I): <https://www.aids.gov/pdf/hhs-ssp-guidance.pdf>; (3) recent CDC estimates of county-level HIV and HCV vulnerability by van Handel et al., County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States, Journal of Acquired Immuno-Deficiency Syndromes (2016) and (4) CDC Surveillance for Viral Hepatitis – United States, 2014 <https://www.cdc.gov/hepatitis/statistics/index.htm>

Applicants will need to demonstrate that their projects target rural areas of the United States. They should provide a rationale for this “rural” focus that makes use of the multiple US government criteria for “rural” geography and/or other allowances based on population size that are mentioned below. There are a number of different geographic classifications for “rural” including those developed by the US Census Bureau, the National Center for Health Statistics, the US Department of Agriculture and the Health Resources and Services Administration (HRSA). These definitions vary in their level of restrictiveness and their relationship with rural health and public health service programs. The following is a HRSA-supported website that provides links for these criteria and an interactive decision tool that may be helpful to applicants in developing their rationale: <https://www.ruralhealthinfo.org/am-i-rural/help>. In addition, projects that are based in Micropolitan Statistical Areas, as defined by the US Office of Management and Budget <https://www.whitehouse.gov/sites/default/files/omb/assets/bulletins/b10-02.pdf> will be considered responsive as will projects that are based in Metropolitan Statistical Areas of 250,000 persons or less.

Because of the epidemiology of opioid use in Appalachia and the limited public health resources in this region, applications targeting rural counties in the Appalachian Region are particularly encouraged. The Appalachian Regional Commission (ARC) has committed up to \$750,000 through the multi-agency POWER 2016 initiative for first year funding of projects. POWER 2016 targets federal resources to help communities and regions that have been affected by job losses in coal mining, coal power plant operations, and coal-related supply chain industries due to the changing economics of US energy production. For this initiative, ARC funds will be awarded only to projects serving “coal- impacted communities” in the Appalachian Region which are those located within and targeted to communities or regions that have been impacted, or can reasonably demonstrate that they will be impacted, by employment loss in coal mining, coal power plants, or in the supply chain industries of either. Supply chain industries include, but are not necessarily limited to, manufacturers of mining equipment and parts for coal-fired powerplants as well as transportation companies that carry coal. For information about ARC and the 420 counties in the Appalachian Region, see www.arc.gov/counties.

Projects funded under this FOA will be expected to collaborate with a site to be funded under RFA-DA-17-023 to build capacity for Global Hepatitis Outbreak and Surveillance Technology (GHOST), a comprehensive system that includes next-generation sequencing (NGS) technologies, bioinformatics and computational approaches. GHOST will aid in establishing HCV transmission links, outbreak investigations and molecular surveillance. The GHOST laboratory enables state and local health departments to investigate HCV outbreaks and to identify HCV transmission networks among PWID. By delineating transmission networks, the selected site will provide sequence data to guide public health interventions for disrupting transmission of HCV disease in PWID communities. Together with CDC’s Division of Viral Hepatitis Laboratory Branch, the funded GHOST laboratory will accept specimens from participating Community Response Project sites funded under this FOA and provide viral sequences that will be automatically analyzed at each site, using the GHOST website, to identify HCV transmission links among PWID. In coordination with the CDC laboratory, the GHOST laboratory will participate in testing specimens, depositing sequences and analyzing transmission links among PWID using GHOST. The GHOST laboratory is expected to be integrated with the programs of other sites—namely to be testing specimens from them.

Special Considerations

SAMHSA is interested in supporting substance use disorder treatment and recovery support services related to projects related to this RFA. This includes evidence-based substance use disorder prevention and treatment interventions for clients living with or at high risk for HIV, HCV and related comorbidities in rural communities impacted by opioid injection drug use. SAMHSA's specific interests include client referrals and linkages to medication-assisted treatment (MAT), antiretroviral therapy (ART), Hepatitis A virus (HAV) and HBV vaccination, HCV treatment and syringe service programs (SSPs) along with methods for collecting information confirming client receipt of these types of services. SAMHSA also is interested in supporting testing clients for HIV, HCV, HBV and other sexually transmitted infections (STIs).

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