

CMS Region 7 Updates

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Table of Contents

.....	1
ACA/Marketplace Updates.....	4
CMS Announces Target Markets for Open Enrollment 2017	4
Theme Weeks.....	9
Agent Broker Resource.....	9
Excepted Benefits; Lifetime and Annual Limits; and Short-term, Limited-duration Insurance, Draft Manual for Cost-Sharing Reduction Reconciliation the 2016 Benefit Year Final Rule (9932-F).....	9
HHS Social Media Resources Open Enrollment.....	10
Open Enrollment Key Dates	11
Marketplace Open Enrollment Update: What Consumers Should know about the Marketplace and Plan Year 2017	11
Before Open Enrollment Begins.....	11
After Open Enrollment Begins	12
Consumer Experience Improvements	12
Re-Enrollment Process Updates	15
Important information for the 2017 open enrollment period include:	15
Failure to File: Attestation Question	17
Enrollees with Qualified Health Plans offered by an Issuer that Will Have No Marketplace Option Available to the Enrollee for the Upcoming Year	17
Before the start of Open Enrollment	17
Additional Resources	18
Health Insurance Enforcement and Consumer Protections Cycle I Grant Awards	18
MACRA/Quality Payment Program (QPP) Updates.....	21
Vermont All-Payer ACO Model.....	21

Final Rule Governing Excepted Benefits Coverage, Lifetime and Annual Limits, and Short-Term Limited Duration Coverage is Available.....	22
13.8 Million Individuals Are Expected to Select a Plan During 2017 Open Enrollment.....	22
CMS Released 2014 Issuer Level Enrollment Data.....	23
Frequently Asked Questions About Affordable Care Act Implementation is Available.....	23
10.4 Million Consumers Had Effectuated Health Insurance Marketplace Coverage	23
Draft Quality Rating System (QRS) QHP List Will be Available on November 7, 2016	23
“The Impact of Obamacare in Four Maps”	24
Ladies Wear Blue for Men’s Health.....	25
Medicare and Medicaid Updates	26
CMS Announces Final Payment Changes for Medicare Home Health Agencies for 2017 (CMS-1648-F)	26
CMS Updates to Policies and Payment Rates for End-Stage Renal Disease Prospective Payment System (CMS 1651-F).....	29
Date Change & Phased Enforcement of Part D Prescriber Enrollment	35
CMS Announces Updates to Dialysis Facility Compare: Patient Experience Ratings Now Available	36
CMS Hospital Value-Based Purchasing Program Results for Fiscal Year 2017	37
Medicare Learning Network Provider News.....	39
News & Announcements	39
Provider Compliance	40
Upcoming Events	40
Medicare Learning Network® Publications & Multimedia	40
Upcoming Webinars and Events and Other Updates	41
CMS 2016 Quality Conference - December 13-15, 2016 Register Now!	41
Marketplace Exemptions Webinar.....	41
Newly Posted Training Materials.....	41
New / Updated CMS Publications.....	42
CMS Hospital/Quality Initiative Open Door Forum	42
Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call – November 2.....	43
Home Health Quality Reporting Program Provider Training – November 16 and 17.....	44
Get Link'd 2nd Annual Conference.....	44
Assister Summit (Save the Date).....	44

Learn More about the New Medicare Quality Payment Program – Upcoming Webinar 44

Quality Payment Program Final Rule MLN Connects® Call – November 15 45

October 26, 2016 Webcast "Quality Payment Program Overview" Replay..... 45

Webinar. A Look Behind the Curtain: Health Care Reform and the Path to Equity..... 45

Veterans & Hepatitis C: Test, Treat, Cure 45

Region VII Heart Disease Disparities Report Webinar..... 46

2016 Health Insurance Marketplace Training Calendar for CMS Partners 47

HRSAs’ Open Funding Opportunities 47

Toolkits and Resources to Prepare for Open Enrollment in the Health Insurance Marketplace 47

**2016 Health Insurance Marketplace Training: Health Insurance Marketplaces: Information for
Immigrant Families..... 48**

Complex Eligibility Scenarios 48

Preventing & Resolving Data-Matching Issues 48

ACA/Marketplace Updates

CMS Announces Target Markets for Open Enrollment 2017

Local Partnerships and Focused Communication Will Help Drive Enrollment

The Centers for Medicare and Medicaid Services (CMS) announced 15 target markets for this year's Open Enrollment. As in previous years, the target markets will be a particular focus for outreach, travel, and collaborations with local partners, also in addition to other nationwide efforts to [step up outreach](#).

“We look forward to engaging Americans all across the country in Open Enrollment beginning November 1, but we are especially excited for a major outreach push in these 15 terrific markets where we've seen success in the past and where the potential for enrollment growth remains high,” said Kevin Counihan, CEO of the Marketplace. “Local partnerships and focused communications will ensure that residents of these metro areas know that affordable coverage is available and that we're here to help them enroll.”

The top 15 target markets for Open Enrollment this year are: **Miami-Fort Lauderdale, FL; Dallas-Fort Worth, TX; Atlanta, GA; Houston, TX; Tampa-St. Petersburg, FL; Orlando-Daytona-Melbourne, FL; Northern New Jersey; Chicago, IL; Philadelphia, PA; Charlotte, NC; Detroit, MI; Salt Lake City, UT; Phoenix, AZ; St. Louis, MO; and San Antonio, TX.** These markets were selected based on three criteria: (1) they present strong opportunities for meaningful enrollment increases; (2) high percentage of eligible uninsured; and (3) Open Enrollment has been successful in these metro areas in the past.

Market	Open Enrollment 3 Plan Selections
Miami, FL	643,911
Dallas, TX	382,669
Atlanta, GA	443,720
Houston, TX	346,822
Tampa, FL	284,753
Orlando, FL	329,684
Northern New Jersey	228,538
Chicago, IL	310,523
Philadelphia, PA	291,175
Charlotte, NC	208,622
Detroit, MI	180,516
Salt Lake City, UT	176,096
Phoenix, AZ	144,196
St Louis, MO	134,934
San Antonio, TX	120,351
TOTAL	4,226,510

We expect those numbers to grow this year, since these markets together still include more than 3 million Marketplace-eligible uninsured Americans.

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. And, experts continue to find that [nearly half](#) of uninsured adults are unaware of the financial assistance available to help pay for health insurance. [About 85 percent](#) of Marketplace-eligible uninsured Americans could qualify for financial help. To get the word out, focused outreach in the top 15 target markets will heighten awareness of coverage options in these key metro areas and complement nationwide outreach efforts.

No one has more influence and understanding of their community than local organizations. We will be working with groups on the ground to get the word out about affordable coverage and helping people to enroll. On top of that, our outreach efforts in these markets will benefit from more travel, more advertising, and more earned media.

PARTNERING WITH LOCAL ORGANIZATIONS

We'll be partnering with local entities from colleges and fraternities to city governments to private companies to get the word out about affordable coverage.

- **Philadelphia: Philadelphia Gas Works (PGW)**, in partnership with Enroll America, is supporting efforts to reduce the number of uninsured residents in Philadelphia. PGW will host trained health care navigators at each of its six Customer Service Centers to help people sign up for coverage and will include information in bill inserts sent to 500,000 household across its service area.
- **Chicago:** The **Chicago Housing Authority** will send regular emails to more than 25,000 housing residents before enrollment deadlines and **Chicago Public Schools' Medicaid counselors** will make referrals for parents to get navigator assistance with enrollment in Marketplace.
- **Northern New Jersey:** For the third year in a row, the brothers of the **Omega Psi Phi Fraternity** will be hosting enrollment events in communities throughout New Jersey. The Omegas have fostered relationships with current students at their respective colleges and even deeper connections within the communities and places of worship that they belong to and often lead.
- **Dallas, Ft. Lauderdale, and Atlanta:** GGP, owner and operator of high-quality regional shopping centers nationwide, will play an active role in open enrollment by distributing background information on the Affordable Care Act to consumers. They will also host navigators and assisters in their Dallas, Ft. Lauderdale and Atlanta properties.
- **Tampa:** The **Tampa Mayoral office** continues to be a partner by opening up the doors of community resources to allow residents a place to find enrollment assistance. Some of the resources they will be leveraging this year include recreation centers as enrollment sites, enrollment information on the city website, tabling /marketing opportunities at City co-sponsored events, enrollment promotion on social media, and utility mailings.
- **Atlanta: Georgians for a Healthy Future** has trained dozens of enrollment assisters and will be educating hundreds of consumers through its innovative new program, G.E.A.R., the Georgia

Enrollment Assistant Resource Guide, while also producing a series of “how to” videos to be shared via their social media campaigns.

- **Detroit:** The **Detroit Health Department** will promote the ACA to the parents of children participating in the WIC and immunization programs they conduct through the Detroit public school system. In addition, the Health Department will promote open enrollment in school based health centers.

WORKING WITH LOCAL COALITIONS

We’ll be partnering with active local coalitions committed to bringing access to affordable coverage to their communities.

- **Dallas:** The Enroll North Texas ACA Coalition consists of 30 organizations across multiple counties. The Coalition membership includes partners from the office of elected officials, churches, community health centers, colleges, hospitals, insurers and multiple assister organizations. They will be partnering with local malls and neighborhood organizations in the Dallas area to drive enrollment events and opportunities.
- **Miami:** The Miami-Dade/Ft. Lauderdale/West Palm Beach coalition –led by the Health Councils in the respective counties and includes an array of city and county representatives, colleges and universities, health providers and non-profit organizations – will work with local partners to stand up enrollment events as well as target and canvass neighborhoods with high numbers of uninsured residents.
- **Northern New Jersey:** New Jersey Citizen Action (NJCA) has been an advocate, collaborator, partner and lead organizer on the Affordable Care Act in New Jersey. NJCA convenes the state’s leading health care consumer coalition – NJ for Health Care – which includes dozens of community based organizations, and other health care stakeholders. They facilitate an ACA Work Group and its website CoverNJ.org which once again this year boasts local resources, enrollment events and detailed information for New Jerseyans seeking coverage.
- **Orlando:** The Central Florida Enrollment Coalition (based in Orlando) is comprised of organizations such as the Hispanic Health Initiative, Enroll America, FCIU, CHCF, Planned Parenthood (PPFA), Healthy Start, United Way, PICO, the Florida Association of Community Health Centers (FACHS), and EAC contractors, all of whom will work to drive enrollment among their membership and constituencies throughout Open Enrollment.
- **Phoenix:** Cover Arizona is a statewide coalition of 600 organizations and 300 individual members committed to increasing health coverage. Members are engaged in building awareness of opportunities available through the Health Insurance Marketplace and AHCCCS, Arizona’s Medicaid program. Members are actively engaged in local outreach activities, and are committed to ensuring that trained enrollment assisters are available for consumers seeking coverage. Members include county health departments, hospitals, non-profits, community health centers, health systems, the faith community, educational institutions, and more.

- **St. Louis:** Enrollment efforts in St. Louis are coordinated by the Cover Missouri Coalition, an alliance of 954 members led by Missouri Foundation for Health. The coalition has helped thousands in St. Louis enroll in affordable health insurance, including traditionally uninsured artists and musicians, cab drivers and hospitality employees. Through its online Find Local Help tool, the coalition allows Missouri residents to find and schedule appointments with free, local enrollment counselors. A mentoring program pairs new staffers with seasoned enrollment counselors to ensure that consumers receive the best information about their insurance options.
- **San Antonio:** Through a partnership with the City of San Antonio and Bexar County, the Enroll San Antonio Coalition will have enrollment assistors at local libraries twice a week throughout open enrollment. Additionally, the West Side Community Center in New Braunfels, Texas provides space to schedule a variety of enrollment events and serve to enroll community members

OFFERING IN-PERSON ASSISTANCE IN KEY LOCATIONS

Many people prefer in-person assistance. To help meet consumers where they are, HHS will have storefronts in each of these target markets where people can get confidential, in-person assistance by trained assisters. We'll also be engaging with community-based locations where residents can get assistance and enroll.

- **Philadelphia:** Consumers will be able to get in-person assistance at various locations around the City like the Free Libraries of Philadelphia, Community Health Centers, and the Friends Center.
- **Charlotte:** Charlotte's lead navigator, Legal Services of Southern Piedmont, will partner with local businesses and neighborhoods to host a series of events throughout Open Enrollment including one in partnership with the Renaissance West Community. Together they will host a "Kick off to get covered" outreach and enrollment event at Renaissance West housing community on November 1st starting at 4pm.
- **Houston:** Enroll Gulf Coast Collaborative will provide enrollment information and support at Houston Health Department Multi-Service and Health Centers located across the city. In addition, special Affordable Care Act activities will be held at colleges, universities and local events.
- **Salt Lake City:** The Take Care Utah coalition is led by the Association for Utah Community Health (AUCH), the Utah Health Policy Project (UHPP), and the United Way 2-1-1 and consists of over 30 organizations and over 100 enrollment assisters. Take Care Utah's work with the Salt Lake County Health Department has led to a partnership with WIC clinics for outreach and enrollment. Enrollment specialists are on site at WIC clinics on a weekly basis.
- **Phoenix:** As is years past, many City of Phoenix schools will be opening their doors for navigators to hold regular enrollment hours on campuses. In addition, there is enrollment happening all across the community at WIC clinics, Public Health Department immunization sites, libraries, schools, churches, and community health centers.

OUTREACH AND ON-THE-GROUND COMMUNICATIONS

On top of the email, television, mail, and social media that we'll use to reach Americans across the country, target markets will see:

- **More travel.** Health and Human Services Secretary Burwell, CMS Acting Administrator Andy Slavitt, or Marketplace CEO Kevin Counihan will be visiting each of these markets at least once

during Open Enrollment to speak with local assisters and advocates who are on the front lines of Open Enrollment; meet individuals who've found affordable plans for themselves and their families; and sit down with local media to talk about what open enrollment means to the communities they cover. Throughout Open Enrollment, other Cabinet officials from across the Administration will be visiting some of these markets as well for similar activities.

- **Targeted advertising.** We'll be doing targeted advertising in these markets to ensure consumers have the information they need to find affordable plans that work for them. We'll have outdoor advertising for HealthCare.gov in these markets, especially in areas with high concentrations of the uninsured. The digital advertising we're running across the nation will be delivered heavily in each of these markets. And we'll be buying mobile advertising in these markets, which will be especially effective at reaching younger populations on their phones and tablets.
- **More earned media.** Throughout Open Enrollment, we'll be focusing earned media outreach in these markets, working with local newspapers, radio and TV, to make sure consumers in their area know they can find affordable coverage and all the ways we're here to help them enroll. Lastly, travel by the HHS Secretary and others will be supplemented by call-in's to radio shows or remote appearances on local TV throughout Open Enrollment, particularly around deadlines and other key milestones. HHS is also developing partnerships with local influencers – radio show hosts, DJs, and athletes – to drive media around deadlines and help reach communities where they are.

Getting Ready for Open Enrollment

We're putting the finishing touches on our plans for Open Enrollment 4. Between now and November 1, you'll see a series of announcements from us about what's new, what's better, and what to expect during this Open Enrollment – including new tools for consumers, new outreach tactics and targeting strategies, and more information about continued access to affordable coverage. Today's announcement is the sixth in this series. The first, on September 27th, focused on [outreach to young adults](#), while the second, on October 4th, focused on outreach to [off-Marketplace consumers](#) eligible for financial help. The third, on October 13, highlighted how we were using [smarter targeting and new tactics](#) to improve outreach in OE 4. The fourth, on October 19, provided Marketplace enrollment projections for OE4. The fifth, on October 24, launched Window Shopping encouraging consumers to come to HealthCare.gov to see their options for coverage in 2017 before Open Enrollment begins on November 1st.

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

###

Theme Weeks

Open Enrollment 2017

Week Of	Theme
October 3 rd , 10 th , & 17 th	Coalition, Local, and National Partnership Building Focus
October 24 th	Countdown to Enrollment Focus
October 31 st	Open Enrollment Has Begun, LEP Week of Action
November 7 th	Open Enrollment Has Begun, Faith Weekend of Action
November 14 th	Native American Week of Action, Rural Health Week of Action
November 21 st	Thankful for Coverage Week of Action, Small Business Saturday
November 28 th	Private-Sector Week of Action, Re-Enrollment and Enrollment Deadline Push
December 5 th	LGBT Week of Action, Men's Week of Action, Philanthropy/Foundations Week of Action, National Youth Enrollment Day, Re-Enrollment and Enrollment Deadline Push
December 12 th	Young Invincibles Week of Action, Re-Enrollment and Enrollment Deadline Push
December 19 th	Give the Gift of Health Care, Faith Week of Action, Women's Week of Action
December 26 th	Health and Wellness/New Year's Resolution Week of Action
January 2 nd	Health and Wellness/New Year's Resolution Week of Action, Men's Week of Action
January 9 th	Latino Week of Action and State and Local Official Week of Action
January 16 th	African American Week of Action, AAPI Week of Action, and Faith Week of Action
January 23 rd	Deadline Focus and Strong Final Push
January 30 th	Deadline Focus and Strong Final Push

6

Agent Broker Resource

[Plan Year 2017 Open Enrollment: A Primer for Agents and Brokers Participating in the Marketplace](#)

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Excepted Benefits; Lifetime and Annual Limits; and Short-term, Limited-duration Insurance, Draft Manual for Cost-Sharing Reduction Reconciliation the 2016 Benefit Year Final Rule (9932-F)

The Departments of HHS, Labor, and the Treasury issued joint final rules that increase transparency and avoid coverage gaps for consumers with short-term, limited-duration insurance. The rules also clarify the standards for travel insurance and supplemental health insurance to be excepted benefits. The rules being released today were initially proposed in June 2016 and are being finalized without substantive change.

Click here to view the notice at the Federal Register:

<https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance> (<https://federalregister.gov/d/2016-26162>).

###

HHS Social Media Resources Open Enrollment

November 1st, we kick off the fourth Open Enrollment for the Health Insurance Marketplace! Americans will be able to visit HealthCare.gov to shop for and enroll in an affordable health plan for 2017. This year, we'll be using social media more than ever before to get the word out to consumers to #GetCovered. It's more important than ever that we share key messages about Open Enrollment:

- **Financial help is available to help keep coverage affordable.**
- **Signing up is easier and faster than ever.**
- **Help is available! Free, confidential help can be found in person or by phone.**
- **All consumers will have choices, and can compare plans by total costs, doctor network, or covered prescriptions.**
- **December 15 is the deadline if you want to be covered at the start of the new year.**

HHS has developed an Open Enrollment Social Media Toolkit full of resources to help you participate in these efforts. The toolkit includes key Open Enrollment messages, graphics and video, a social media calendar and more. It will be updated throughout Open Enrollment #4 and will be your one-stop-shop for #GetCovered content.

- [Social Media Resources: Open Enrollment 2017](#)

Wednesday, November 2	@What to Expect, Women & Vaccines, Twitter Chat, 2pm EDT #GetCovered,
Thursday, November 3	#ACALangAccess OMH Twitter Storm, 2-3 p.m., EDT #GetCovered

For more information on these and other digital events please go to the [Open Enrollment Google Calendar](#).

Thank you in advance for taking part in this effort. Together, we've helped millions of Americans find the peace of mind that comes with quality, affordable health coverage. That works continues on Tuesday, and we are grateful for partnership!

Heidi Christensen, Associate Director for Community Engagement

Center for Faith-based and Neighborhood Partnerships/IEA/OS

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###

Open Enrollment Key Dates

Open Enrollment 2017

Key Dates	
November 1, 2016	Open enrollment begins
December 15, 2016	The last date to enroll for coverage that starts January 1, 2017 and the final day that 2016 enrollees can change policies before being “auto-reenrolled” in their previous plan
December 31, 2016	The date when all 2016 Marketplace coverage ends, no matter when you enrolled
January 1, 2017	The date 2017 coverage can start if you enroll by December 15, 2016
January 15, 2017	The last date to enroll for coverage that starts February 1, 2017
January 31, 2017	Last day to enroll in 2017 coverage (coverage starts March 1, 2017)

Partners to Consider
Small Business Owners, On-Demand Economy Partners
Local Elected Officials
Faith Leaders and Institutions
Local Coalitions
Digital and Community Influencers
Providers
Patient Groups

###

Marketplace Open Enrollment Update: What Consumers Should know about the Marketplace and Plan Year 2017

- [Before Open Enrollment Begins](#)
- [After Open Enrollment Begins](#)
- [Consumer Experience Improvements](#)
- [Re-Enrollment Process Updates](#)
- [Failure to File: Attestation Question](#)
- [Enrollees with Qualified Health Plans offered by an Issuer that Will Have No Marketplace Option Available to the Enrollee for the Upcoming Year](#)
- [Standing Assister Resources: Helpful Links / Call Center Hours / Contact Us](#)

Before Open Enrollment Begins

Before Open Enrollment begins, all consumers should receive the following:

Marketplace Open Enrollment Notice (MOEN) from the Marketplace.

This notice outlines the Open Enrollment dates as well as other important messages for the consumer to consider such as whether they are at risk of losing their Advanced Payments of the Premium Tax Credit (APTC), whether or not they are still eligible to receive APTC to help lower their premium payments or if they have an unresolved Data Matching Issue.

Issuer Notice

Also during this time, consumers who are current Marketplace enrollees will receive letters from their current insurance companies that provide information on the availability of their plan, cost and benefit changes for the upcoming plan year and notification if their existing plan won't be offered on the Marketplace for the 2017 plan year.

After Open Enrollment Begins

Consumers should return to the Marketplace starting November 1st, update their application for 2017, view and shop for plans, and confirm and enroll in a plan to be sure they receive the right amount of financial assistance and are enrolled in the best plan for themselves and their families for coverage beginning January 1, 2017.

We encourage assisters to conduct widespread outreach to current enrollees to encourage them to return to the Marketplace between November 1, 2016 and January 31, 2017 to update their application and select a plan for 2017 coverage that best meets their needs. Assisters are permitted to reach out to consumers who have given their consent for assisters to follow up with them about applying for or enrolling in coverage.

NOTE: While helping consumers apply for or re-enroll in coverage for the 2017 Plan Year, don't forget to answer the question that asks if someone is helping you apply/enroll in coverage. Federally-facilitated Marketplace Navigators, Certified Application Counselors (CAC) and Enrollment Assistance Personnel are encouraged to enter their 13 digit alphanumeric ID number for this question

Consumer Experience Improvements

The process to apply for coverage will primarily remain the same for the 2017 plan year. The Marketplace has worked to streamline and enhance the consumer experience for this Open Enrollment period so consumers may notice the following improvements when enrolling for coverage beginning November 1st:

Integrated educational and decision support: These features will help consumers see whether *doctors, drugs, and facilities* are covered in their plan. This year, we're helping consumers up front who have specific doctor and drug needs. Consumers can add in their doctors and drugs, so that when they see their plan results, which doctors and drugs are covered by each plan are already visible as they review their options. In addition, consumers will now be able to filter plans based on specific doctors, drugs and facilities in combination with other things that are important to them (such as price, deductible, plan type, and more).

Enter your your doctors, medical facilities & prescription drugs to see if they're covered

You save money by using doctors and facilities (like hospitals and pharmacies) in a plan's network -- and drugs it covers.

Search for and select your doctors, facilities, and prescription drugs.

When you compare plans, you'll see if the selected doctors and facilities are in a plan's network, and if your drugs are covered. *(Information on group practices will be available in the future.)*

Remember: Insurance companies update doctors and drugs that are covered or in their network throughout the year. Before you enroll, you should confirm with your doctor and the plan you're considering that they're currently covered.

Enter ONE doctor, medical facility, or drug at a time

SEARCH

SKIP

Abilities to view estimates of yearly costs: Consumers have the option to select an estimated level of health care utilization of Low, Medium or High for each person to see an estimate for what total out of pocket costs maybe when viewing and comparing plans.

1 2 3 4 5 6 7 8 9 10 | Total estimated costs TO DO LIST / CHANGE MY INFORMATION

See estimates of each plan's total yearly costs

When you compare plans it's important to think about **all** your costs for the year, not just your monthly payment. Total costs for any health plan include:

Yearly Premiums

Your monthly premium payment x 12 months

Yearly deductible

The amount you pay each year before the plan pays anything. \$0 to several thousand dollars, depending on plan.

Copayments & Coinsurance

Charges (a set dollar amount or percentage) each time you visit a doctor, get care, or buy a prescription drug.

Total yearly costs

To see estimates of total yearly costs, pick a level of care below. When you shop, we'll show each plan's total estimated yearly costs for that amount of care.

+ + =

What level of medical care do you think **Suzanne Carson** will use this year?

Just pick the one that seems closest to what you expect. When you shop, we'll show your **total estimated yearly costs** for each plan based on this level of care. Picking a level **won't** affect your premiums or access to care. You can change to see total costs for other care levels later on.

LOW

MEDIUM

HIGH

You expect to use about this much care this year:

- 8 doctor visits
- 3 lab or diagnostic tests
- 15 prescription drugs
- \$400 in other medical costs

Simple Choice Plans: Consumers that are interested in looking at Simple Choice plans will have the option to pre-filter their plan results so they see just those plans. Consumers that want to view all plans first and then narrow their options later will see a tag for Simple Choice plans within their results to help them filter out the Simple Choice plans on their own.

Want to start with the easiest way to compare plans?

All "Simple Choice" plans in the same category (like Silver) have the same benefits, deductibles and copayments. This way, you can quickly compare "Simple Choice" plans in any category based on:

- Monthly premiums
- Doctors and hospitals in their network
- Additional services covered

Simple Choice plans have many similar features but also offer differences in doctors and drugs covered which can lead to different premiums.

You can start by looking at "Simple Choice" plans, then easily see all plans later. Or you can see all plans to start and then view only "Simple Choice" ones.

SEE ALL PLANS

SEE ONLY SIMPLE CHOICE PLANS

Other improvements include a completely mobile optimized user interface, streamlined on screen content with improved integrated help for each step, including definitions, hover tool tips and continuous progression through the enrollment steps for an improved navigational experience.

Re-Enrollment Process Updates

Each year, Marketplaces must redetermine the eligibility of consumers enrolled in coverage through the Marketplace. For an enrollee who does not contact the Marketplace to obtain an updated eligibility determination and select a QHP by December 15, 2016, the Marketplace will establish 2017 eligibility for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) based on the most recent household income data available, together with updated federal poverty level (FPL) tables and benchmark plan premium information, and reenroll the enrollee in their same, or similar plan, effective January 1, 2017.

All consumers who are auto re-enrolled by the Marketplace receive an updated Eligibility Determination Notice (EDN). In 2017, consumers who are auto-re-enrolled in 2017 will now see the income that was used to redetermine their eligibility in the results box in their EDN.

Important information for the 2017 open enrollment period include:

(1) *Content will be tailored for re-enrolling consumers throughout the application and enrollment flow. Re-enrolling consumers must review their 2016 applications and update them before re-enrolling in 2017 coverage.*

(1a) Applications will be pre-populated for re-enrollees with the information from the last version of their 2016 application if enrollees or their assisters use the existing Marketplace Account. It's important that consumers first search for a pre-populated application before creating a new application to enroll, or else the enrollee may be inconvenienced by multiple invoices or other issues.

(1b) Re-enrolling consumers must take the following steps to get coverage for 2017:

- Review the application, and make any necessary updates to relevant information, like changes to income or household composition.
- Submit the application.
- View "Eligibility Results."

- Choose and enroll in a plan, even if the consumer wants to keep the same plan. Consumer should do this by **December 15**, to prevent a break in coverage.

(1c) Enrollees may use their Marketplace Account to indicate that they don't want to be auto-reenrolled for 2017. This will send a December 31, 2016, termination transaction to their current issuer and prevent them from being auto-reenrolled (or cancel their auto-reenrollment if already sent)

(1d) Web brokers are now required to search for existing applications before creating a new application in order to prevent disconnected applications that aren't pre-populated with the enrollees most recent eligibility information. This will help reduce duplicate enrollments that create service issues for the enrollee and reconciliation challenges for the issuer.

Note: It's really important for consumers to make sure that after doing any application updates (even if they want to stay in the same plan), to go through the entire application and re-select and confirm their plan. Consumers that need to report a 2016 life change must go to the 2016 application to update their application and enrollment. 2016 changes made before December 16 will be carried forward to the auto-reenrolled policy. Once an enrollee has made an update to their 2017 enrollment, subsequent updates to the 2016 policy will not be automatically carried forward.

(2) The FFM will calculate eligibility for 2017 APTC and CSRs using the most recent family income data available and updated FPL.

(3) The FFM will discontinue APTC/CSRs for enrollees who fall into one of the following groups:

- Did not authorize the Marketplace to check IRS data
- Tax data reflects that their annual income is over 500% FPL
- Previously received APTC but the tax filer for the household failed to file a federal tax return and reconcile the APTC for that year
- Applied in 2014, were auto-renewed without application updates for 2015 and 2016, and who have no available tax data (new for 2017, see below).

Note: Any consumer who enrolled with APTC for 2016 and fall into one of the four categories above, will receive content on their Marketplace Open Enrollment Notice (MOEN) that includes language warning them that they are at risk for losing financial assistance and urging them to actively apply and reenroll, though the category is not disclosed on the MOEN. For example, an enrollee who received APTC in 2014 or 2015 but whose tax filer has not filed a tax return and reconciled APTC for that year will receive a target Marketplace Open Enrollment Notice (MOEN) that includes language warning them that they are at risk for losing financial assistance. In this example, the enrollee's tax filer should take action immediately to file a tax return(s) and let the Marketplace know that they filed by attesting on the application. In December, before auto re-enrollment concludes, the Marketplace will check IRS data again to identify any late-filers. The Marketplace discontinues financial assistance for consumers who received APTC in a past year, have not filed a tax return and reconciled the APTC for that year or previous years, and have not attested on the application to having filed their tax return.

(3a) In addition, the Marketplace will be discontinuing APTC and CSRs for a new population of consumers who meet the following criteria:

- Authorized the Marketplace to check data about their income and household size,
- Were automatically reenrolled by the Marketplace for coverage in 2015 and 2016 with APTC or CSRs

- Did not submit an updated application that was used to enroll in a Marketplace plan for coverage in 2015 or 2016, and
- No income information for this household is available from the Internal Revenue Service (**IRS**) for **tax years 2015 or 2014.**

Note: For consumers who fall into this category (called “Repeat Passive Re-enrollees”), the Marketplace will send a targeted (MOEN) letting them know they are at risk for losing financial assistance if they do not update their information.

Failure to File: Attestation Question

Like last year, the Marketplace application will include a tax filing-related question, but it has been updated to accommodate multiple tax years. This question allows enrollees who received APTC to attest, under penalty of perjury, to having filed a tax return and reconciled APTC for any past year they received APTC. After filing and reconciling the APTC, attesting to having filed a tax return on the application allows the enrollee to maintain eligibility for APTC while IRS processes the return and updates its data.

Enrollees with Qualified Health Plans offered by an Issuer that Will Have No Marketplace Option Available to the Enrollee for the Upcoming Year

Some issuers may not have any Marketplace enrollment options available to some or all of their enrollees for coverage in 2017. The Marketplace will match these enrollees to an alternate plan from a different insurance company. This new policy will help protect enrollees from having a gap in coverage.

Before the start of Open Enrollment

Current issuers send discontinuation notices to enrollees indicating that they aren’t offering Marketplace coverage to them in 2017. The Marketplace sends outreach letters and emails to some targeted, impacted enrollees encouraging them to shop for and enroll in a plan that meets their needs and budget.

- Emphasizes the December 15 deadline for January 1 coverage (to avoid a gap in coverage)
- Mentions that the Marketplace has matched enrollees with an alternate plan, but that enrollees are under no obligation to enroll in that plan

Mid-November:

The Marketplace sends an official notice to impacted enrollees reinforcing that their issuer isn’t offering coverage available to them in the Marketplace in 2017, with emphasis on explaining that the Marketplace has matched them with an alternate plan, and providing the name of the new plan and issuer.

- Informs enrollees that they may get information from this plan, but they don’t have to enroll in it
- Continues to encourage enrollees to shop for and enroll in a plan that meets their needs and budget

Week of November 21:

Alternate plan issuers mail welcome package and premium payment bill.

Messages assisters should share with consumers:

- Your current insurance company isn’t offering a plan available to you through the Marketplace in 2017.
- You need to shop for a new plan to find one that meets your needs and budget.
- Select a plan by December 15 for coverage starting January 1 so you don’t have a gap in coverage.

Post-December 15 messages:

- If you like the alternate plan the Marketplace has matched you with, just pay the premium bill this insurance company sends you.
- You can still choose another plan anytime during the Open Enrollment (OE)
- OE runs November 1, 2016 through January 31, 2017
- Enrollees in these plans are eligible for a loss of minimum essential coverage special enrollment period.

Additional Resources

- **MOEN examples can be found online under the heading of Open Enrollment Notices at <https://marketplace.cms.gov/applications-and-forms/notices.html>**
- **Annual Redetermination and Re-enrollment guidance <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ARR-2017-Guidance-051016-508.pdf>**

We encourage assisters to conduct widespread outreach to current enrollees to encourage them to return to the Marketplace between November 1, 2016 and January 31, 2017 to update their application and select a plan for 2017 coverage that best meets their needs. **Assisters are permitted to reach out to consumers who gave their consent to have assisters follow up with them about applying for or enrolling in coverage.**

We will be providing additional information about the 2017 reenrollment process in the coming weeks.

###

Health Insurance Enforcement and Consumer Protections Cycle I Grant Awards

The Centers for Medicare & Medicaid Services (CMS) awarded approximately \$25.5 million to 22 states and the District of Columbia to use for enforcement and oversight of issuer compliance with select Affordable Care Act (ACA) key consumer protections. These awards allow states to use the funding for activities related to planning and implementing selected Federal market reforms and consumer protections including: essential health benefits, preventive services, parity in mental health and substance use disorder benefits, appeals processes, and bringing down the cost of health care coverage (also known as medical loss ratio (MLR) provision).

These additional grants will help support State Departments of Insurance efforts to make sure their laws, regulations, and procedures are in line with Federal requirements and that states are able to effectively oversee and enforce issuer compliance with consumer protections guaranteed by the ACA. State Departments of Insurance are vital to the oversight of health insurance issuers and are responsible for ensuring premiums are reasonable and justified, companies are solvent, and consumers are protected.

Grant Awards Overview:

Approximately \$21.6 million is being awarded to assist State Departments of Insurance in planning and implementing select key insurance market reforms and consumer protections (see Table 1 for a breakdown

by market reform). The remaining funds will be used towards other allowable expenses under the grant to fund other activities that are not directly related to planning or implementing a single market reform, but that extend across all of the select key market reforms (such as travel, supplies and equipment, and indirect costs). The grant will have a project and budget period of 24 months from the award date, October 31, 2016, to October 30, 2018. Each applicant awarded a grant will receive a minimum baseline amount of \$476,998 (see table 2 for award totals by state). However, some states chose to request less than the minimum baseline amount. In addition to receiving a baseline award each applicant awarded a grant will also receive funding for the “Selected Market Reforms” and “Workload” funds. Workload funds are determined based on the population and number of health insurance issuers in the State.

Table 1: Funding Breakdown by Market Reform

Market Reform	Total Award Amount (approx.)	Number of Jurisdictions to Receive Funding
Essential Health Benefits (Section 2707)	\$3.5M	16 ^[1]
Preventive Health Services (Section 2713)	\$5.3M	19 ^[2]
Bringing down the Cost of Health Care Coverage (MLR) (Section 2718)	\$1.4M	10 ^[3]
Appeals Process (Section 2719)	\$2.1M	11 ^[4]
Parity in Mental Health and Substance Use Disorder Benefits (Section 2726)	\$9.3M	20 ^[5]

Grants will be awarded to the District of Columbia and the following states: Alaska, California, Colorado, Hawaii, Illinois, Indiana, Kentucky, Massachusetts, Maryland, Michigan, Minnesota, Mississippi, North Carolina, Nebraska, New Hampshire, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Utah, and Washington.

Table 2: Health Insurance Enforcement and Consumer Protections Cycle I Grant Awards by State

#	State	Total Award Amount
1	Alaska	\$629,841.00

^[1] Jurisdictions receiving funding for Section 2707: CA, CO, DC, HI, IL, IN, MI, MN, MS, NH, NM, OR, PA, RI, UT, WA.

^[2] Jurisdictions receiving funding for Section 2713: CA, CO, DC, HI, IL, IN, KY, MA, MI, MN, MS, NC, NE, NH, NM, OR, PA, RI, UT.

^[3] Jurisdictions receiving funding for Section 2718: CA, CO, HI, IL, IN, KY, MA, MS, PA, UT.

^[4] Jurisdictions receiving funding for Section 2719: AK, CO, DC, HI, IL, IN, MI, NE, PA, RI, UT.

^[5] Jurisdictions receiving funding for Section 2726: CA, CO, DC, HI, IL, IN, MA, MD, MI, MN, MS, NC, NE, NH, NM, NY, OR, PA, RI, UT.

2	California	\$1,844,585.00
3	Colorado	\$1,328,508.00
4	District of Columbia	\$1,138,052.09
5	Hawaii	\$1,210,906.86
6	Illinois	\$1,377,567.36
7	Indiana	\$1,297,729.08
8	Kentucky	\$873,652.00
9	Massachusetts	\$1,206,525.03
10	Maryland	\$249,070.00
11	Michigan	\$1,024,301.64
12	Minnesota	\$1,160,020.69
13	Mississippi	\$1,152,710.14
14	North Carolina	\$1,114,013.82
15	Nebraska	\$1,068,804.31
16	New Hampshire	\$1,120,164.00
17	New Mexico	\$1,159,064.00
18	New York	\$1,244,446.34
19	Oregon	\$1,245,919.00
20	Pennsylvania	\$1,486,251.00
21	Rhode Island	\$1,090,263.35
22	Utah	\$996,216.82
23	Washington	\$528,441.00
	Total	\$25,547,052.53

Background on Funding:

The ACA provided \$250 million in state rate review grants to improve the process for how states review proposed health insurance rate increases and hold insurance companies accountable for unjustified hikes. In 2015, rate review led to an estimated \$1.5 billion in savings for consumers.^[6] The funds announced today are unobligated rate review grant funding from prior years. Consistent with statute, rate review grant funds not fully obligated by the end of fiscal year 2014 are available to HHS to issue grants to states for planning and implementing the insurance market reforms and consumer protections under Part A of title XXVII of the Public Health Service Act.

For more information on the grant awards, visit: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Health_Insurance_Enforcement_and_Consumer_Protections-Grants-.html

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^[6] Rate Review Annual Report: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf

MACRA/Quality Payment Program (QPP) Updates

Vermont All-Payer ACO Model

The Centers for Medicare & Medicaid Services (CMS) and the state of Vermont jointly announced today the Vermont All-Payer Accountable Care Organization (ACO) Model, a new initiative aimed at accelerating delivery system reform for Vermont residents. The Vermont All-Payer ACO Model aims to transform health care for the entire state and its population. Through the model, the most significant payers throughout the state – Medicare, Medicaid, and commercial health care payers – will incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state’s care delivery system. Today, CMS also approved a five-year extension of Vermont’s section 1115(a) Medicaid demonstration, which, in addition to extending the state’s comprehensive demonstration, includes the authorities needed to make Medicaid a full partner in the Vermont All-Payer ACO Model.

CMS and Vermont aim for broad ACO participation throughout the state -- across all the significant payers and the majority of the care delivery system -- to make redesigning the entire care delivery system a rational business strategy for Vermont payers and providers, and to deliver meaningful improvements in the health of and health care for Vermonters.

“This model is historic in terms of its scope, aiming to include almost all providers and people throughout the state in an all-payer ACO model to drive improved quality, better care coordination, healthier people, and smarter spending,” said Patrick Conway, M.D., CMS principal deputy administrator and chief medical officer. “This model may also allow eligible physicians and other clinicians in Vermont to qualify for Advanced Alternative Payment Model bonus payments from the Quality Payment Program given their commitment to be accountable and improve care for patients.”

The Vermont All-Payer ACO Model is an exciting advancement in CMS’ partnerships with states to accelerate delivery system reform. CMS has been partnering with Maryland for the past three years as part of the Maryland All-Payer Model to shift hospital payments to global budgets that reward value over volume. The Vermont All-Payer Model builds on the Maryland All-Payer Model by expanding statewide health care transformation beyond the hospital and will provide valuable insight for other state-driven all-payer payment and care delivery transformation efforts.

The Vermont All-Payer ACO Model offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the state and will provide Vermont start-up funding of \$9.5 million to assist medical providers with care coordination and bolster their collaboration with community-based providers. Additionally, the section 1115(a) Medicaid demonstration extension enables Medicaid, a critical health care payer in the Vermont All-Payer ACO Model, to enter into ACO arrangements that align with that of other health care payers in support of the Vermont All-Payer ACO Model. Under the Vermont All-Payer ACO Model, the state commits to achieving statewide health outcomes, financial, and ACO scale targets across all significant health care payers.

CMS is excited about the promise of the Vermont All-Payer ACO Model to improve health care value and quality. In addition, CMS seeks public input on additional opportunities to partner with states on payment and care delivery reform. On September 8, 2016, CMS released a [request for information](#) on concepts related to state-based payment and delivery system reform initiatives.

The Affordable Care Act, through the creation of the Center for Medicare and Medicaid Innovation, allows for the testing of innovative payment and service delivery models, such as the Vermont All-Payer ACO Model, to move our health care system toward one that rewards clinicians based on the quality, not quantity, of care they give patients. Today’s announcement is part of the Administration’s broader strategy to improve the health care system by paying providers for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality.

In March 2016, the Administration estimates that it met the ambitious goal – eleven months ahead of schedule – of tying 30 percent of Medicare payments to quality and value through alternative payment models by 2016. The Administration’s next goal is tying 50 percent of Medicare payments to alternative payment models by 2018. The Health Care Payment Learning and Action Network established in 2015 continues to align efforts between government, private sector payers, employers, providers, and consumers to broadly scale these efforts to achieve better care, smarter spending, and healthier people.

For more information on the Vermont All-Payer ACO Model and the section 1115(a) Medicaid demonstration extension, please visit:

- Vermont All-Payer ACO Model: <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>
- Vermont section 1115(a) demonstration extension: [Fact Sheet](#) and [CMS Approval Letter](#)
- Vermont’s Green Mountain Care Board: <http://gmcboard.vermont.gov/payment-reform/APM>
- Vermont All-Payer ACO Model Fact Sheet: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-25.html>

###

Final Rule Governing Excepted Benefits Coverage, Lifetime and Annual Limits, and Short-Term Limited Duration Coverage is Available

The Departments of HHS, Labor, and the Treasury issued [joint final rules](#) that increase transparency and avoid coverage gaps for consumers with short-term, limited-duration insurance. The final rule also clarifies the standards for travel insurance and supplemental health insurance to be excepted benefits, and amends a reference in the final regulations relating to the prohibition on lifetime and annual dollar limits.

###

13.8 Million Individuals Are Expected to Select a Plan During 2017 Open Enrollment

CMS released a [brief](#) which looks ahead to estimate how many individuals nationwide might select a Marketplace plan during the upcoming Open Enrollment period and how many – on average throughout 2017 – might have Marketplace coverage. By the end of open enrollment for 2017, CMS expects 13.8 million people to have selected a plan and estimate that 11.4 million individuals will effectuate their enrollment on an average monthly basis over the course of 2017.

###

CMS Released 2014 Issuer Level Enrollment Data

In an effort to make the health care system more transparent, CMS has prepared [public data sets](#) to provide the total number of health plan selections by county for the 36 states that were served by Marketplaces that used the HealthCare.gov platform for enrollment in individual market Marketplaces in the 2014 benefit year. These tables include county-level and issuer plan selection information organized by age, household income as a percentage of the Federal Poverty Level (FPL), plan, gender, and tobacco status.

###

Frequently Asked Questions About Affordable Care Act Implementation is Available

HHS, Department of Labor, and Treasury jointly released an [FAQ](#) that extends prior enforcement relief provided in Technical Release 2016-01, which stated 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).

###

10.4 Million Consumers Had Effectuated Health Insurance Marketplace Coverage

CMS/CCIIO released the first half of [2016 Effectuated Enrollment Snapshot](#) which found an average of 10.4 million consumers had effectuated Health Insurance Marketplace coverage. This includes those individuals who have paid their premiums and had an active policy through one of the Health Insurance Marketplaces nationwide as of that date. Effectuated enrollment is generally lower in January and February, since coverage purchased in the weeks before the final Open Enrollment deadline does not begin until March. June effectuated enrollment was slightly higher than the average for the first half of the year, about 10.5 million.

###

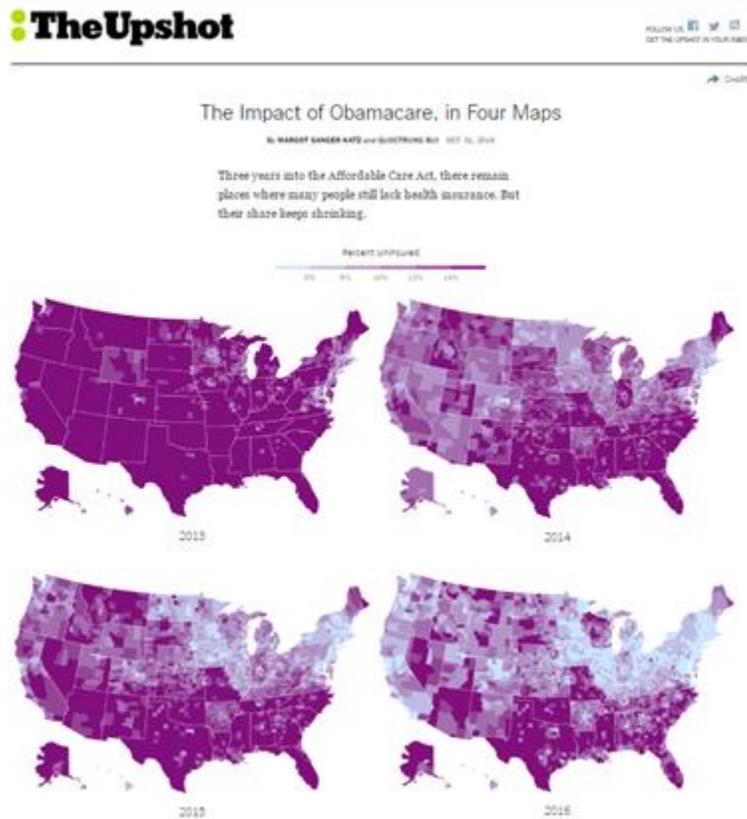
Draft Quality Rating System (QRS) QHP List Will be Available on November 7, 2016

The draft QRS QHP List will be available via CMS' Health Insurance Oversight System Marketplace Quality Module (HIOS-MQM) on 11/7/2016. This list includes QHP issuers operating in the 2016 plan year and is intended to facilitate QHP issuer preparation for meeting the 2017 QRS and QHP Enrollee Survey requirements. QHP issuers that operated in 2016, and are certified to operate in 2017, should reference the file to determine whether updates to the list are necessary.

###

“The Impact of Obamacare in Four Maps”

New York Times published an [article](#) with maps and graphics based on data from our uninsured model. The article is headlined “The Impact of Obamacare, in Four Maps,” and the overall takeaway is that – despite current controversy – the Affordable Care Act continues to reduce the uninsured rate in a truly historic way, particularly in places that embrace it and work to help people enroll.



###

Ladies Wear Blue for Men's Health



Whether they are our fathers or sons or neighbors, men's health is a critical issue in our communities. Women serve as trusted voices and influencers to the men in their lives on a variety of issues, including their health.

Join women around the country and wear blue November 11- 13 for men's health!

- **Wear blue** at services in faith and community settings **November 11th-13th**
 - Take a picture that weekend wearing blue and share your photo on social media using the hashtag **#LadiesWearBlue**
- **Key Messages**
 - Visit [HealthCare.gov](https://www.healthcare.gov) or [CuidadoDeSalud.gov](https://www.cuidadodesalud.gov).
 - Connect to information with [Healthy Young America; HealthYI app; The Get Covered Plan Explorer](#))
 - Get in person assistance. Visit [Find Local Help on Healthcare.gov](#), [Enroll America's Connector](#) or [Out2Enroll's Connector](#))

Also check out [Brother2 Brother](#) to help men talk to their brothers, male friends and family members about health and health coverage

Medicare and Medicaid Updates

CMS Announces Final Payment Changes for Medicare Home Health Agencies for 2017 (CMS-1648-F)

Today, the Centers for Medicare & Medicaid Services (CMS) announced final changes to the Medicare home health prospective payment system (HH PPS) for calendar year (CY) 2017 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Approximately 3.4 million beneficiaries received home health services from approximately 11,400 home health agencies, costing Medicare approximately \$18.2 billion in 2015.

In the final rule, CMS estimates that Medicare payments to home health agencies in CY 2017 would be reduced by 0.7 percent, or \$130 million based on the finalized policies. The estimated decrease reflects the effects of the 2.5 percent home health payment update percentage (\$450 million increase); the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor (an impact of -2.3 percent or a \$420 million decrease); and the effects of the -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth, for an expected impact of -0.9 percent (a \$160 million decrease).

To be eligible for the home health benefit, beneficiaries must need intermittent skilled nursing or therapy services and must be homebound and under the care of a physician. Covered home health services include skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, medical social services, and medical supplies. Home Health Agencies (HHAs) are paid a national, standardized 60-day episode payment for most covered home health services, adjusted for case-mix and area wage differences.

The HH PPS final rule is one of several rules for calendar year 2017 that reflect a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people. Provisions in these rules are helping to move our health-care system to one that values quality over quantity and focuses on reforms such as achieving better health outcomes, preventing disease, helping patients return home, helping manage and improve chronic diseases, and fostering a more efficient and coordinated health care system.

Payment Policy Provisions

Rebasing the 60-day Episode Rate

The Affordable Care Act directs CMS to apply an adjustment to the national, standardized 60-day episode rate and other applicable amounts to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. CMS must phase-in any adjustment over a four-year period, in equal increments, not to exceed 3.5 percent of the amount (or amounts) as of the date of the enactment of the Affordable Care Act (CY 2010).

In this final rule, CMS would complete the final year of the four-year phase-in of the rebasing adjustments to the HH PPS payment rates. As finalized in the CY 2014 final rule, the CY 2017 rebasing adjustment to

the national, standardized 60-day payment rate is -\$80.95. The overall impact due to the rebasing adjustments is estimated to be a 2.3 percent decrease in HH PPS payments for CY 2017. As noted above and further below, this is offset by the home health payment update percentage, which would increase overall HH PPS payments in CY 2017 by 2.5 percent.

Updates to Reflect Case-Mix Growth

CMS will implement a 0.97 percent reduction to the national, standardized 60-day episode rate in CY 2017 to account for nominal case-mix growth from 2012 to 2014 (prior to rebasing). CY 2017 will be the second year of the three-year phase-in of the reduction to account for nominal case-mix growth. The -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth results in an estimated decrease in HH PPS payments for CY 2017 of -0.9 percent.

Negative Pressure Wound Therapy (NPWT)

The Consolidated Appropriations Act, 2016, requires a separate payment to be made to HHAs for NPWT using a disposable device when furnished on or after January 1, 2017 to an individual who receives home health services for which payment is made under the Medicare home health benefit. As described in the Consolidated Appropriations Act, 2016, the separate payment amount for an applicable disposable device will be set equal to the amount of the payment that would otherwise be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS).

Change in Methodology and the Fixed-Dollar Loss (FDL) Ratio Used to Calculate Outlier Payments

CMS finalized the proposal to change the methodology used to calculate outlier payments, moving from a cost per visit approach to a cost per unit approach (1 unit = 15 minutes). This approach more accurately reflects the cost of an outlier episode of care and thus better aligns outlier payments with episode costs than the cost-per-visit approach. In addition, CMS finalized the proposal to increase the FDL ratio from 0.45 to 0.55 in order to ensure outlier payments do not exceed 2.5 percent of total payments for CY 2017, as required by the Social Security Act.

Other Updates

CMS has also updated the HH PPS payment rates by the home health payment update percentage of 2.5 percent, as required by the Social Security Act.

Home Health Quality Reporting Program (HH QRP) Update

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) requires the public reporting of data on HHAs, Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs) quality measures and data on resource use and other measures. The Act also requires the Secretary to modify PAC assessment instruments to provide for the submission and comparison of standardized, and interoperable, patient assessment data on quality measures. These requirements are intended to enable interoperability as well as improve quality and discharge planning, among other purposes.

Following opportunities for proposed rule public comment, as well as measure development related technical expert review and public comment and the review by the measures application partnership process, in this final rule and beginning with the CY 2018 payment determination, CMS adopted four

measures to meet the requirements of the IMPACT Act. Three of these measures are calculated using Medicare claims. The Total Medicare Spending per Beneficiary - Post Acute Care Home Health Quality Reporting Program (MSPB-PAC HH QRP) measure does not require additional data submission. The fourth measure is assessment-based and is calculated using Outcome and Assessment Information Set (OASIS) data. The various measures are as follows:

- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Post-Acute Care Home Health Quality Reporting Program;
- Total Medicare Spending per Beneficiary - Post Acute Care Home Health Quality Reporting Program (MSPB-PAC HH QRP);
- Discharge to Community- Post Acute Care Home Health Quality Reporting Program; and
- Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care Home Health Quality Reporting Program.

The Home Health Conditions of Participations (CoPs) require HHAs to submit OASIS assessments for quality measurement purposes; submission of OASIS data is also required as a condition of payment. HHAs that do not submit quality measure data to CMS will see a 2.0 percent reduction in their annual payment update (APU). Last year CMS finalized its proposal to require all HHAs to submit both admission and discharge OASIS assessments for a minimum of 90 percent of all patients with episodes of care occurring during the reporting period. CMS is incrementally increasing this compliance threshold from 70 percent to 90 percent over a three-year period beginning with the reporting period for CY 2017 (July 1, 2015-June 30, 2016).

In 2015, CMS undertook a comprehensive reevaluation of all 81 HH quality measures, some of which are used only in the Home Health Quality Initiative (HHQI), and others which are also used in the HH QRP. The goal of this reevaluation was to streamline the measure set, consistent with Measures Management System (MMS) guidance and in response to stakeholder feedback. This reevaluation included a review of the current scientific basis for each measure, clinical relevance, usability for quality improvement, and evaluation of measure properties, including reportability and variability.

CMS's measure development and maintenance contractor convened a Technical Expert Panel (TEP) on August 21, 2015, to review and advise on the reevaluation results. Information regarding the TEP's feedback is available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Health-Quality-Reporting-Program-HHQRP-TEP-.zip>. As a result of the comprehensive reevaluation, CMS identified 28 HHQI measures that were either "topped out" and/or determined to be of limited clinical and quality improvement value by TEP members. Therefore, these measures will no longer be included in the HHQI. A list of these measures, along with our reasons for no longer including them in the HHQI, can be found at the following link: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html>. In addition, based on the results of the comprehensive reevaluation and the TEP input, we finalized to remove six process measures from the HH QRP, beginning with the CY 2018 payment determination, because they are "topped out" and therefore no longer have sufficient variability to distinguish between providers in public reporting.

Home Health Value-Based Purchasing Model

In the CY 2016 Home Health Prospective Payment System final rule, CMS finalized its proposal to implement the Home Health Value-Based Purchasing (HHVBP) Model in nine states representing each geographic area in the nation. For all Medicare-certified home health agencies (HHAs) that provide

services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, payment adjustments will be based on each HHA's total performance score on a set of measures already reported via OASIS and HHCAHPS for all patients serviced by the HHA, or determined by claims data, plus three new measures where points are achieved for reporting data.

The HHAs in these nine states will have their payments adjusted (upward or downward) in the following manner: a maximum payment adjustment of three percent in CY 2018; a maximum payment adjustment of five percent in CY 2019; a maximum payment adjustment of six percent in CY 2020; a maximum payment adjustment of seven percent in CY 2021; and, a maximum payment adjustment of eight percent in CY 2022.

In the CY 2017 Home Health Prospective Payment System final rule, in addition to providing an update on the progress towards developing public reporting of performance under the HHVBP Model, CMS is finalizing the following changes and improvements related to the HHVBP Model:

- Calculate benchmarks and achievement thresholds at the state level rather than the level of the size-cohort and revise the definition for "benchmark" to state that benchmark refers to the mean of the top decile of Medicare-certified HHA performance on the specified quality measure during the baseline period calculated for each state;
- Require a minimum of eight HHAs in any size-cohort;
- Increase the timeframe for submitting New Measure data from seven calendar days to fifteen calendar days following the end of each reporting period to account for weekends and holidays;
- Remove four measures (Care Management: Types and Sources of Assistance, Prior Functioning ADL/IADL, Influenza Vaccine Data Collection Period, and Reason Pneumococcal Vaccine Not Received) from the set of applicable measures;
- Adjust the reporting period and submission date for the Influenza Vaccination Coverage for Home Health Personnel measure from a quarterly submission to an annual submission; and
- Implement the recalculation and reconsideration processes.

For additional information about the Home Health Prospective Payment System, visit <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html>.

For additional information about the Home Health Value-Based Purchasing Model, visit <https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model>.

The final rule can be viewed at <https://www.federalregister.gov/public-inspection>.

###

CMS Updates to Policies and Payment Rates for End-Stage Renal Disease Prospective Payment System (CMS 1651-F)

Quality Improvement Program, Coverage and Payment for Acute Kidney Injury, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program and Fee Schedule, and Comprehensive End-Stage Renal Disease Care Model

OVERVIEW: On October 28, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective

Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2017. This rule also finalizes new quality measures to improve the quality of care by dialysis facilities treating patients with ESRD.

The ESRD PPS final rule is one of several rules for calendar year (CY) 2017 that reflect a broader Administration-wide strategy to deliver better care at lower cost through improved methods to deliver care, pay providers, and use information. Provisions in these rules are helping to move our health care system to one that values quality over quantity and focuses on achieving better health outcomes, preventing disease, helping patients live successfully at home, helping manage and improve chronic diseases, and fostering a more efficient and coordinated health care system.

This rule also implements the Trade Preferences Extension Act of 2015 (TPEA) provisions regarding the coverage and payment of renal dialysis services furnished by ESRD facilities to individuals with acute kidney injury (AKI).

The ESRD PPS final rule also made changes to the ESRD Quality Incentive Program (QIP), including payment years (PYs) 2019 and 2020, under which payment incentives are applied to dialysis facilities to improve the quality of care that they provide. Under the ESRD QIP, facilities that do not achieve a minimum Total Performance Score (TPS), with respect to their performance on quality measures established by regulation, receive a reduction in their payment rates under the ESRD PPS. For PY 2019, CMS finalized substantive updates to the Hypercalcemia clinical measure to align with the measure that is National Quality Forum (NQF) endorsed and will continue to satisfy the statutory requirements under the Protecting Access to Medicare Act of 2014 (PAMA) for measures specific to conditions treated with oral-only medications.

In addition, CMS made changes to the scoring methodology for the ESRD QIP for PY 2019 and added one new measure. For PY 2020, CMS will: 1) replace the Mineral Metabolism reporting measure with an NQF-endorsed Serum Phosphorus reporting measure; and 2) add two new measures to the ESRD QIP. CMS also finalized changes to certain administrative requirements and programmatic policies to the ESRD QIP.

This final rule also addresses issues related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and the DMEPOS Competitive Bidding Program (CBP).

CMS is finalizing a requirement for bidding entities to obtain and provide proof of a bid surety bond for each competitive bidding area (CBA) in which the entity submits its bid(s), in accordance with Section 1847(a)(1)(G) of the Social Security Act, as added by section 522(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The rule also finalizes revisions to the existing state licensure requirement at §414.414(b)(3) to conform with the requirements in section 522(b) of MACRA, and expands suppliers' appeal rights in the event that CMS takes one or more of the breach of contract actions specified in §414.422(g)(2).

Finally, the final rule changes the methodologies for adjusting DMEPOS fee schedule amounts using information from the DMEPOS Competitive Bidding and for establishing single payment amounts under the Competitive Bidding Programs for certain groups of similar items (e.g., various types of walkers) with different features (e.g., walkers with wheels versus walkers without wheels). Changes are also finalized for the methodology used to establishing bid limits for items under the DMEPOS Competitive Bidding Program.

CHANGES TO THE ESRD PPS FOR CY 2017:

ESRD PPS Background: Section 153(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the Social Security Act to require CMS to implement a bundled PPS for renal dialysis services furnished to Medicare beneficiaries for the treatment of ESRD effective January 1, 2011. The bundled payment under the ESRD PPS includes all renal dialysis services furnished for outpatient maintenance dialysis, including drugs and biologicals (with the exception of oral-only ESRD drugs until 2025) and other renal dialysis items and services that were formerly separately payable under the previous payment methodologies. The bundled payment rate is case-mix adjusted for a number of factors relating to patient characteristics. There are also facility-level adjustments for ESRD facilities that have a low patient volume or rural locality, and for wage index. An ESRD facility may be eligible for outlier payments for high-cost patients. Under the ESRD PPS for CY 2017, Medicare expects to pay approximately \$9.0 billion to approximately 6,000 ESRD facilities for the costs associated with furnishing chronic maintenance dialysis services.

Update to the ESRD PPS Base Rate: The finalized CY 2017 ESRD PPS base rate is \$231.55. This amount reflects a reduced market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (0.55 percent), application of the wage index budget-neutrality adjustment factor (0.999781), as well as the application of a home and self-dialysis training budget-neutrality adjustment factor (0.999737). The finalized CY 2017 ESRD PPS base rate is an increase of \$1.16 from the CY 2016 base rate of \$230.39 ($230.39 \times 1.0055 = \231.66; $\$231.66 \times 0.999781 = \231.61 ; $\$231.61 \times 0.999737 = \231.55).

Annual Update to the Wage Index and Wage Index Floor: The ESRD wage indices are adjusted on an annual basis using the most current hospital wage data and the latest Core-Based Statistical Area (CBSA) delineations to account for differing wage levels in areas in which ESRD facilities are located. For CY 2017, CMS is not finalizing any changes to the application of the wage index floor, and will continue to apply the current wage index floor (0.4000) to areas with wage index values below the floor.

Update to the Outlier Policy: Using the most current data, CMS is finalizing an update to the outlier services fixed-dollar loss amounts and Medicare Allowable Payments (MAP) for adult and pediatric patients for CY 2017 using 2015 claims data. Based on the use of more current data, the fixed-dollar loss amount for pediatric beneficiaries will increase from \$62.19 to \$68.49 and the MAP amount will decrease from \$39.20 to \$38.29, compared to CY 2016 values. For adult beneficiaries, the fixed-dollar loss amount will decrease from \$86.97 to \$82.92 and the MAP amount will decrease from \$50.81 to \$45.00. In 2015, outlier payments represented 0.9 percent of the 1.0 percent outlier target percentage. Using CY 2015 claims data to update the outlier MAPs and fixed-dollar loss amounts for CY 2017 will increase outlier payments for ESRD beneficiaries requiring higher resource utilization.

Impact Analysis: CMS projects that the updates for CY 2017 will increase the total payments to all ESRD facilities by 0.73 percent compared with CY 2016. For hospital-based ESRD facilities, CMS projects an increase in total payments of 0.9 percent, while for freestanding facilities, the projected increase in total payments is 0.7 percent. Aggregate ESRD PPS expenditures are projected to increase by approximately \$80 million from CY 2016 to CY 2017.

Home and Self-Dialysis Training Add-on Payment Adjustment: CMS is finalizing an increase to the home and self-dialysis training add-on payment adjustment. CMS calculated the increase based on the average treatment times and weights for each modality and then used those times and weights as proxies for the total time spent by nurses training beneficiaries for home or self-dialysis. Using an updated RN hourly wage of \$35.94 and an increase to the hours of nurse training time from 1.5 hours to 2.66 hours, the CY

2017 home and self-dialysis training add-on payment adjustment is \$95.60, an increase of \$45.44 from the current training add-on amount of \$50.16.

COVERAGE AND PAYMENT FOR RENAL DIALYSIS SERVICES FURNISHED TO INDIVIDUALS WITH ACUTE KIDNEY INJURY (AKI):

In accordance with sections 1861(s)(2)(F) and 1834(r) of the Act, as amended by sections 808(a) and 808(b), respectively, of the TPEA, CMS will provide coverage and payment for renal dialysis services furnished on or after January 1, 2017 by an ESRD facility to an individual with AKI. Under the law, the payment will be the amount of the ESRD PPS base rate, as adjusted by the wage index. CMS is finalizing that drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish, but that are not renal dialysis services, may be paid for separately when furnished to individuals with AKI.

CHANGES TO THE ESRD QIP

ESRD QIP Background: Section 153(c) of the MIPPA required CMS to establish an ESRD QIP that selects measures, establishes performance standards, specifies a performance period for each PY, assesses the total performance of each facility, applies an appropriate payment reduction to each facility that does not meet a minimum TPS, and publicly reports the results. The ESRD QIP is intended to promote high-quality care by dialysis facilities treating beneficiaries with ESRD. This program changes the way CMS pays for the treatment of ESRD patients by linking a portion of payment directly to facilities' performance on quality measures. The ESRD QIP will reduce payments by up to two percent to ESRD facilities that do not meet or exceed a minimum TPS.

The PY 2018 ESRD QIP: There were no changes to the PY 2018 ESRD QIP. The PY 2018 ESRD QIP measure set finalized in the CY 2016 ESRD PPS Final Rule, contains eight clinical measures and three reporting measures encompassing anemia management, dialysis adequacy, vascular access type (fistula and catheter), patient experience of care, infections, hospital readmissions, and mineral metabolism management.

Changes to the PY 2019 ESRD QIP: CMS finalized the creation of a new Safety Measure Domain as a third category of measures for PY 2019. CMS finalized the inclusion of the National Healthcare Safety Network (NHSN) Dialysis Event reporting measure (as expanded in PY 2015) into the ESRD QIP measure set for PY 2019, and then combined this measure with the existing NHSN Bloodstream Infection (BSI) clinical measure in a new NHSN BSI Measure Topic, which will be the only measure topic in this new Safety Measure Domain.

Additionally, CMS finalized two substantive changes to the Hypercalcemia clinical measure for PY 2019 to ensure that the measure remains in alignment with the measure specifications endorsed by the National Quality Forum (NQF), which continues to satisfy PAMA requirements. These changes involve updating the measure's technical specifications for PY 2019 and future years to include plasma as an acceptable substrate in addition to serum calcium. First, CMS added plasma as an acceptable substrate in addition to serum calcium. Second, CMS changed the calculation of the revised measure to include patient-months with missing values in order to minimize any incentive for a facility to avoid reporting serum calcium data.

Changes for the PY 2020 ESRD QIP: The PY 2020 ESRD QIP measure set contains eight clinical measures and seven reporting measures encompassing anemia management, dialysis adequacy, vascular access type, patient experience of care, infections, mineral metabolism management, safety, pain

management, depression management, and hospital readmissions. CMS also finalized two additional measures for PY 2020.

In June, CMS proposed to apportion 80 percent of a facility's TPS to the Clinical Measure Domain, and 10 percent each to the Reporting Measure Domain and the Safety Measure Domain. In response to public comments received during the public comment period, however, CMS has not finalized this proposal. Instead, CMS will maintain the scoring methodology it finalized for PY 2019: which is to apportion 75 percent of a facility's TPS to the Clinical Measure Domain, 15 percent of the TPS to the Safety Measure Domain, and 10 percent to the Reporting Measure Domain.

- **Clinical Measures:** CMS added the Standardized Hospitalization Ratio (SHR) clinical measure beginning in PY 2020. This addition reflects CMS's priority to ensure that the ESRD QIP maintains the most broadly applicable clinical measures that capture the quality of care provided to as many beneficiaries with ESRD as possible.
- **Reporting Measures:** CMS adopted a new Ultrafiltration Rate reporting measure for PY 2020. CMS also replaced the Mineral Metabolism reporting measure (based on claims data) with a new Serum Phosphorus reporting measure that uses CROWNWeb data.

Additional ESRD QIP Components:

CMS will continue CMS's pilot program to validate data that facilities enter into CROWNWeb. The Final Rule also increased the size of the NHSN validation study, and revised the methodology to determine whether a facility reported dialysis events for patients in accordance with the NHSN Dialysis Event Protocol.

CHANGES TO THE DMEPOS COMPETITIVE BIDDING PROGRAM:

Background: Section 1847 of the Act, as amended by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires the Secretary to establish and implement the DMEPOS Competitive Bidding Program in areas throughout the United States. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas (CBAs). Section 522(a) of MACRA amended section 1847 of the Act to require a bid surety bond and applicable state licensure for bidding entities.

Bid Surety Bond: The final rule requires bidding entities to obtain a bid surety bond, from an authorized surety on the Department of the Treasury's Listing of Certified Companies, for each CBA associated with their bid. The bid surety bond is finalized at \$50,000 and must indicate the CBA specific to that bond.

This rule also finalizes forfeiture conditions for these bid surety bonds. In the event that a bidding entity does not accept a contract offer(s) when its composite bid is at or below the median composite bid rate for suppliers used in the calculation of the single payment amount(s), the bid surety bond(s) for the applicable CBA(s) will be forfeited and CMS will collect on the bid surety bond(s). In instances where the bidding entity does not meet the bid surety bond forfeiture conditions specified in the rule, the bid surety bond liability will be returned to the bidding entity within 90 days of the public announcement of the contract suppliers for the CBA.

Bidding entities that provide a falsified bid surety bond may be prohibited from participation in the DMEPOS Competitive Bidding Program for the current round of competition in which they submitted a

bid, as well as from the next round of competition. Bidding entities that provide a falsified bid surety bond will also be referred to the Office of Inspector General and the Department of Justice for further investigation. The final rule also specifies that if CMS finds that a bidding entity has accepted a contract offer and then breached the contract in order to avoid bid surety bond forfeiture, the breach will result in termination of the contract and preclusion from participation in the next round of competition in the DMEPOS Competitive Bidding Program.

State Licensure: The final rule aligns the regulation with the requirement of section 1847(b)(2)(A) of the Act, as amended by section 522(b) of MACRA, to state that a contract will not be awarded to a bidding entity unless the entity meets applicable state licensure requirements. This revision does not reflect a change in policy as CMS already has a regulation in place that requires suppliers to meet applicable State licensure requirements.

Appeals Process for a Breach of Contract Action(s): This rule extends the appeals process to all breach of contract actions that CMS may take under the DMEPOS Competitive Bidding Program, rather than just for contract termination actions. As a result, CMS will issue a notice of breach of contract, which will include any breach of contract action(s) CMS intends to take. The final rule also removes from §414.422(g)(2) certain breach of contract actions that CMS may take.

Bid Limits: This final rule establishes that bid limits for individual items for future rounds of competitions under the DMEPOS Competitive Bidding Program will be based on the fee schedule rates for the items before they are adjusted based on competitive bidding information. This will avoid a downward trend where the new, lower bid limits apply to each subsequent round of bidding based on fee schedule rates adjusted using bidding information from the previous round. This will help to enhance the long term viability of the program and allow suppliers to take into account both decreases and increases in costs in determining their bids, while ensuring that payments under the program do not exceed the amounts that would otherwise be paid had the DMEPOS Competitive Bidding Program not been implemented.

CHANGES TO THE DMEPOS COMPETITIVE BIDDING PROGRAM AND FEE SCHEDULE FOR SIMILAR ITEMS WITH DIFFERENT FEATURES:

CMS is finalizing a policy to address inverted prices for similar items with different features under competitive bidding prior to adjusting fee schedule amounts paid in non-competitive bidding areas. CMS will use the weighted average of the prices for the similar items in a product category as the revised price for the items that will then be used to adjust the fee schedule amounts. CMS is also finalizing a policy to address situations where price inversions have occurred in the past under the bidding programs by finalizing an alternative “lead item” bidding methodology for certain items in future rounds of competitions. Under this method, a supplier submits one bid for a combination of HCPCS codes for similar items with different features. The supplier’s bid for the grouping of HCPCS codes is based on the bid for the lead item, which is the item with the most allowed services among the similar items. The payment rate for the lead item is based on the median of the bids, while the payment rate for the other codes with different features is based on a ratio of the average of the payment amounts for each code for all areas nationwide to the average of the payment amounts for the lead item for all areas nationwide.

The final rule can be found in the October 28, 2016 Federal Register and can be downloaded from the Federal Register at: <http://www.federalregister.gov/inspection.aspx>.

###

Date Change & Phased Enforcement of Part D Prescriber Enrollment

Summary & Background

CMS published a final rule in May 2014 and an interim final rule in May 2015 addressing prescriber enrollment requirements in Medicare. Prescribers must be enrolled in an active status or validly opted out, except in very limited circumstances, in order for their written prescriptions to be covered under Part D. CMS previously announced that enforcement of the prescriber enrollment requirement would begin on February 1, 2017. While CMS is committed to the implementation of the prescriber enrollment requirements, CMS also recognizes the need to minimize the impact on the beneficiary population and ensure beneficiaries have access to the care they need.

To strike this balance, CMS will implement a multifaceted, phased approach that will align full enforcement of the Part D prescriber enrollment requirements with other ongoing CMS initiatives. Full enforcement of the Part D prescriber enrollment requirement will begin on January 1, 2019.

In the lead-up to the January 1, 2019 full enforcement date, CMS will begin phasing in targeted enforcement of the regulation and undertake the following incremental strategic actions designed to increase on-going prescriber enrollment, while protecting beneficiaries and the Medicare program.

- Precluded Physicians and other Prescribers-The prescriber enrollment requirement will be enforced with respect to prescriptions written by individuals who are currently excluded by the OIG, who are revoked by the Medicare program, or who are non-enrolled prescribers with a felony conviction within the last 10 years. (Implementation: Q2 2017)
- Easy Enroll Application Process- CMS will further ease the enrollment application process to enable prescribers to quickly enroll in Medicare for the purpose of prescribing Part D drugs. This process will allow prescribers to review, update, electronically sign and submit a pre-populated enrollment application online. (Implementation: Q2 2017)
- Targeted Risk-Based Prescriber Outreach- CMS will begin targeted, prioritized risk-based outreach and education. This prioritized approach will include direct mailings and coordination with the Part D plans to enroll prescribers of Schedule II drugs or a high volume of Part D drugs. (Implementation: Q2 2017)
- Direct Mailing to all Non-Enrolled Prescribers- CMS will send direct mailings via email and/or paper to all prescribers that are not enrolled in the program. In addition, direct mailing notifications will be triggered for unenrolled prescribers based on Prescription Drug Events. (Implementation: Q3 2017)
- Current Education and Outreach-CMS will continue with the current education and outreach efforts including such activities as stakeholder meetings and conferences, assembly meetings, and presentations. (Continuously on-going)

While the full enforcement date is January 2019, CMS encourages all physicians and eligible professionals who prescribe Part D drugs, but are not yet enrolled or validly opted out of Medicare, to enroll in the Medicare Program. Enrollment information is available at:

For more information, please visit: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Prescriber-Enrollment-About.html>

###

CMS Announces Updates to Dialysis Facility Compare: Patient Experience Ratings Now Available

Today, the Centers for Medicare & Medicaid Services (CMS) announced changes to the [Dialysis Facility Compare](#) (DFC) website on Medicare.gov, which provides information about thousands of Medicare-certified dialysis facilities across the country, including how well those centers deliver care to patients.

These changes are in direct response to the important feedback CMS has received from dialysis patients and their caregivers about what is most important to them in selecting their dialysis facility. CMS remains committed to seeking and incorporating input from all stakeholders, but especially patients, on an ongoing basis so that we can continually improve our Compare sites and make health care quality information more transparent and understandable for patients and their caregivers.

Since the initial release of the Dialysis Facility Compare website, patients have emphasized in their feedback to CMS that understanding how others like them view a dialysis center— in particular the cleanliness of the facility and how well the staff cares for them— is valuable information when choosing a facility. As a result, visitors to the updated Dialysis Facility Compare website will now be able to see how patients rate their experiences with dialysis facilities.

CMS collects patient experience data through the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) Survey, which measures patients' perspectives on the care they received at dialysis facilities. A total of six ratings on patients' experiences with care will be reported, including three that cover specific aspects of patient experience and three overall patient ratings of the kidney doctors, the facility staff and the dialysis facilities. For each dialysis center on Dialysis Facility Compare, the site will include this patient experience information, the quality star rating, and detailed clinical quality information.

CMS is also adding two quality measures to Dialysis Facility Compare:

- The standardized infection ratio (SIR) is a ratio of the number of bloodstream infections that are observed at a facility versus the number of bloodstream infections that are predicted for that facility, based on national baseline data.
- The pediatric peritoneal dialysis Kt/V measure equals the percent of eligible pediatric peritoneal dialysis patients at the facility who had enough waste removed from their blood during dialysis.

Other major changes to the site include modifications to the methodology for calculating dialysis facility star ratings based on recommendations from a 2015 Technical Expert Panel. The updated methodology for calculating star ratings:

- Establishes a baseline to show improvement by taking into account year-to-year changes in facility performance on the quality measures compared to performance standards set in a baseline year. Star ratings will reflect if a facility improves (or declines) in performance over time.
- Limits the impact of a few very low scores by applying a statistical method called truncated z-scores to percentage measures. This ensures that star ratings are not determined by extreme outlier performance on a single measure.
- Ensures accuracy of ratings by keeping the continuity of the measures.

A final change to the DFC website relates to ratio measures:

- The Standardized Mortality Ratio, Standardized hospitalization Ratio, Standardized Transfusion Ratio, and Standardized Readmission Ratio will now be reflected as rates to display them more clearly.

These changes reflect CMS’ ongoing commitment to making sure that Dialysis Facility Compare meets the needs of individuals with kidney disease and their caregivers. This Compare website and today’s updates are part of the agency’s larger effort to make health care quality information more transparent and understandable for consumers. As part of that effort, CMS also has other Compare websites to help in selecting providers across the continuum of care, including [Home Health Compare](#), [Hospital Compare](#), [Nursing Home Compare](#), and [Physician Compare](#).

For more information, see the fact sheet

here: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-28.html>

###

CMS Hospital Value-Based Purchasing Program Results for Fiscal Year 2017

Hospital Value-Based Purchasing Program Overview

The Hospital Value-Based Purchasing (VBP) Program adjusts what Medicare pays hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care they provide to patients. For fiscal year (FY) 2017, the law requires that the applicable percent reduction, the portion of Medicare payments available to fund the program’s value-based incentive payments, increase from 1.75 to 2 percent of the base operating Medicare Severity Diagnosis-Related Group (MS-DRG) payment amounts for all participating hospitals. We estimate that the total amount available for value-based incentive payments for FY 2017 discharges will be approximately \$1.8 billion.

The Hospital VBP Program is one of many Affordable Care Act programs Medicare has established to pay for the quality of care rather than the quantity of services provided to patients. The Hospital VBP Program is part of our long-standing effort to structure Medicare payments to improve care across the entire healthcare delivery system, including hospital inpatient care. In FY 2017, more hospitals will receive positive payment adjustments, indicating improved quality of care and a strong example of better care, smarter spending, and healthier people in action.

Fiscal Year 2017 Hospital VBP Program Results

The domains for the FY 2017 Hospital VBP Program and the weighting for these domains were:

- Clinical Care
 - Outcomes (25 percent)
 - Process (5 percent)
- Patient and Caregiver Centered Experience of Care/Care Coordination (25 percent)
- Safety (20 percent)
- Efficiency and Cost Reduction (25 percent)

We have posted the Hospital VBP incentive payment adjustment factors for FY 2017 in Table 16B, available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service->

This is the fifth year of the Hospital VBP Program, affecting payment for inpatient stays in approximately 3,000 hospitals across the country. Hospitals' payments will depend on:

- How well they performed – compared to their peers – on important healthcare quality and resource use measures during a performance period.
- How much they have improved the quality of care provided to patients over time.

For FY 2017, more hospitals will have an increase in their base operating MS-DRG payments than will have a decrease. In total, over 1,600 hospitals will have a positive payment adjustment.

For FY 2017, about half of hospitals will see a small change in their base operating MS-DRG payments (between -0.5 and 0.5 percent). After taking into account the statutorily mandated 2 percent withhold, the highest performing hospital in FY 2017 will receive a net increase in payments of slightly more than 4 percent, and the lowest performing hospital will incur a net reduction of 1.83 percent.

Computing the VBP Score

The Hospital VBP Program is a budget-neutral program funded each year through a reduction of participating hospitals' base operating MS-DRG payments for the applicable fiscal year. These payment reductions are redistributed to hospitals as incentive payments based on their Total Performance Score (TPS), as required by law. The actual amount earned by each hospital will depend on:

- Its TPS.
- Its value-based incentive payment percentage.
- The total amount available for value-based incentive payments.

Hospitals may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable percent reduction for that program year. This means hospitals could see an increase, a decrease, or no change to their Medicare IPPS payments for the applicable fiscal year. Hospitals excluded from the Hospital VBP Program are not subject to the reduction of 2 percent and are not eligible to receive incentive payments. The total estimated amount available for value-based incentive payments for FY 2017 discharges is about \$1.8 billion.

Hospital TPSs were subject to minimum case and measure requirements. Also, hospitals must have a domain score for at least three of the four domains in order to have a TPS calculated. Hospitals that do not meet the minimum domain requirements do not have their payments adjusted in the corresponding fiscal year. For every measure, each of the hospitals participating in the Hospital VBP Program receives an improvement score and an achievement score; the higher of the two scores is awarded as the measure score.

New Program Requirements for FY 2018

The measure set for the FY 2018 program year includes several changes:

- We are removing two measures from the Clinical Care – Process subdomain (the AMI-7a and IMM-2 measures) and are moving the remaining measure (PC-01) to the Safety domain.

- We are adding a three-item Care Transition dimension, which is part of the Hospital Consumer Assessment of Hospital Providers and Systems (HCAHPS) survey, to the Patient and Caregiver Centered Experience of Care/Care Coordination domain.
- In the Calendar Year (CY) 2017 Outpatient Prospective Payment System (OPPS) proposed rule, we proposed to remove the Pain Management dimension, which is derived from the HCAHPS survey, from the Patient and Caregiver Centered Experience of Care/Care Coordination domain beginning with the FY 2018 VBP program year. We intend to address the proposal and respond to any comments submitted in the CY 2017 OPPS final rule anticipated for release in November 2016.

The FY 2018 Hospital VBP Program will include four equally-weighted domains:

- Clinical Care (25 percent)
- Patient Experience and Caregiver Centered Experience/Care Coordination (25 percent)
- Safety (25 percent)
- Efficiency and Cost Reduction (25 percent)

Moving Forward

As we more closely link patient outcomes and treatment costs to value-based hospital payment, the Hospital VBP Program not only aims for quality gains on paper, it also aims to promote a culture focused on the needs of patients. Value-based purchasing in Medicare continues to move ahead, improving healthcare for people with Medicare now and creating a healthcare system that will ensure better care, smarter spending, and healthier people for generations to come.

Additional Information

For more information on the Hospital VBP Program, please visit the CMS website at:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html> and the QualityNet website at:

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937> .

###

Medicare Learning Network Provider News

News & Announcements

- [Quality Payment Program: Additional Opportunities for Clinicians to Join Innovative Care Approaches](#)
- [Hospital Compare Updated with VA Hospital Performance Data](#)
- [CMS Awards Special Innovation Projects to QIN-QIOs](#)
- [Meeting the Health Challenges of Rural America](#)
- [IRF and LTCH Quality Reporting Program Data Submission Deadline: November 15](#)
- [Revised Home Health Change of Care Notice: Effective January 17, 2017](#)

- [Prepare for ESRD QIP PY 2017 Reporting Documents by Updating your Account](#)
- [Technical Update to 2016 QRDA I Schematrons for eCQM Reporting](#)
- [Check Your Patients Addresses](#)
- [Connect with Us on LinkedIn](#)

Provider Compliance

- [Duplicate Claims](#)

Upcoming Events

- [Social Security Number Removal Initiative Open Door Forum — November 1](#)
- [How to Report Across 2016 Medicare Quality Programs Call — November 1](#)
- [Comparative Billing Report on Subsequent Hospital Care Webinar — November 2](#)
- [Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2](#)
- [Solutions to Reduce Disparities Webinar — November 14](#)
- [Quality Payment Program Final Rule Call — November 15](#)

Medicare Learning Network® Publications & Multimedia

- [Implementation of LTCH PPS Based on Specific Clinical Criteria MLN Matters® Article — New](#)
- [Provider Compliance Fact Sheets — New](#)
- [IMPACT Act Call: Audio Recording and Transcript — New](#)
- [PECOS FAQs Fact Sheet — Revised](#)
- [DMEPOS Information for Pharmacies Fact Sheet — Revised](#)
- [Complying with Documentation Requirements for Laboratory Services Fact Sheet — Reminder](#)
- [Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet — Reminder](#)

[View as a PDF \[PDF, 362KB\]](#)

###

Upcoming Webinars and Events and Other Updates

CMS 2016 Quality Conference - December 13-15, 2016 Register Now!

Join more than nearly 2,000 thought leaders in American health care quality improvement at the CMS 2016 Quality Conference. This conference will explore how patients, advocates, providers, researchers, and the many leaders in health care quality improvement can develop and spread solutions to some of America's most pervasive health system challenges. The 2016 CMS Quality Conference will be the most expansive yet, with both new and existing participants from programs across CMS, HHS, and community stakeholders. The collaborative format of the conference, and strong focus on data-proven outcomes is underscored by this year's conference theme, *Aligning for Innovation and Outcomes*.

For more information and to register, visit the [CMS Quality Conference](#) webpage.

###

Marketplace Exemptions Webinar

November 30, 2016 2:00 – 3:00 pm ET

This webinar will provide an overview of Health Insurance Marketplace exemptions. Topics will include eligibility for exemptions, the filing process for exemptions, review of the Healthcare.gov exemptions screening tool and resources.

To join the webinar, visit goto.webcasts.com/starthere.jsp?ei=1110445.

###

Newly Posted Training Materials

[2016 Medicare Getting Started Training Presentation and Workbook \(Spanish\)](#)

[Understanding Medicare Training Presentation and Workbook \(Spanish\)](#)

[Navigating the Medicare Plan Finder](#)

[Doors to Insurance](#)

[Product Ordering Job Aids](#)

[1-800 Medicare Open Enrollment Presentation](#)

[Medicare Open Enrollment for 2017 Coverage](#)

[Medicare OEP Fraud Prevention Campaign PDF](#)

###

New / Updated CMS Publications

[Have you done your Yearly Medicare Enrollment Review?](#)

[Quick Facts about Medicare Plans and Protecting Your Personal Information](#)

[Understanding Medicare Enrollment Periods](#)

[Things to think about when you compare Medicare drug coverage](#)

###

CMS Hospital/Quality Initiative Open Door Forum

Date: Thursday, November 3, 2016

Start Time: 2:00 PM Eastern Time (ET)

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

****This Agenda is Subject to Change****

I. Opening Remarks

Chair – Tiffany Swygert (Center for Medicare)

Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

Flu Announcement

IMPACT Act announcement

CY 2017 Hospital Outpatient Prospective Payment System (OPPS) Final Rule

III. Open Q&A

Next CMS Hospital/Quality Initiative Open Door Forum: December 6, 2016

ODF EMAIL MAILBOX: Hospital_ODF@cms.hhs.gov

This Open Door Forum is not intended for the press, and the remarks are not considered on the record. If you are a member of the Press, you may listen in but please refrain from asking questions during the Q & A portion of the call. If you have inquiries, please contact CMS at Press@cms.hhs.gov. Thank you.

Open Door Participation Instructions:

This call will be Conference Call Only.

To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 44411292

Persons participating by phone do not need to RSVP. TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Encore: 1-855-859-2056; Conference ID: 44411292

Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID. Encores for ODFs held on Thursdays can be accessed the following Monday. The recording is available for 3 business days.

For ODF schedule updates and E-Mailing List registration, visit our website at <http://www.cms.gov/OpenDoorForums/>.

###

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.

###

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 Webinar

The Centers for Medicare & Medicaid Services (CMS) invites you to join our webinar on **November 15** on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) [final rule with comment period](#). The webinar 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 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](#)

###

October 26, 2016 Webcast "Quality Payment Program Overview" Replay

If you missed the October 26, 2016 webcast titled "Quality Payment Program Overview" it will be available for replay at <https://engage.vevent.com/rt/cms/index.jsp?seid=530>.

###

Webinar. A Look Behind the Curtain: Health Care Reform and the Path to Equity

Hospitals in Pursuit of Excellence (HPOE), in partnership with the Health Research and Educational Trust (HRET): Webinar. *A Look Behind the Curtain: Health Care Reform and the Path to Equity*. Join HPOE, HRET, and speaker Daniel E. Dawes of the Morehouse School of Medicine for a discussion on the ways the ACA has addressed health care disparities. November 8, 2016, 12:00 pm ET. [Register](#).

###

Veterans & Hepatitis C: Test, Treat, Cure

HHS/OMH, OMHRC, in partnership with the Veteran's Health Administration (VHA): Fighting Hepatitis and HIV Co-infection in Minority Communities webinar series. *Veterans & Hepatitis C: Test, Treat, Cure*. This webinar will provide an overview of VHA's viral hepatitis program, including efforts in hepatitis C birth cohort testing and linkage to care. November 10, 2016, 3:00 pm ET. [Register](#).

###

Region VII Heart Disease Disparities Report Webinar

The Heartland Regional Health Equity Council (Heartland RHEC) is hosting a webinar to inform stakeholders about heart disease disparities in Region VII. Region VII encompasses Iowa, Kansas, Missouri, and Nebraska. During this webinar, speakers will provide:

1. An overview of the [Region VII Heart Disease Disparities Report](#);
2. Highlights from data experts regarding heart disease disparities among minority populations for each of the four states in Region VII;
3. An overview of heart disease disparities data for Region VII; and
4. Information for those interested in lowering heart disease rates among racial and ethnic populations in Region VII.

DATE: November 13, 2016

TIME: 1:30 p.m. – 3:00 p.m. Central Standard Time

SPEAKERS:

Facilitator and Speaker: Josie Rodriguez, MS: Administrator, Office of Health Disparities and Health Equity, Nebraska Department of Health and Human Services

Yumei Sun, PhD: Data Manager/Data Specialist, Bureau of Chronic Disease Prevention and Management, Iowa Department of Public Health

Greg Crawford, BA: Director of Vital and Health Statistics Data Analysis Section, Bureau of Epidemiology and Public Health Informatics, Kansas Department of Health and Environment (KDHE)

Craig Ward, MSW: State Registrar, Section of Epidemiology for Public Health Practice, Missouri Department of Health and Senior Services

Anthony Zhang, MA, MPHIL: Epidemiology Surveillance Coordinator, Office of Health Disparities and Health Equity, Nebraska Department of Health and Human Services

Register For more information, please visit here:¹ <http://tinyurl.com/RHECVIIHeartDiseaseWebinar>

For more information, please visit: <http://tinyurl.com/RHECVIISpeakerBios>

Heartland RHEC is one of 10 regional health equity councils formed in 2011 as part of the National Partnership for Action to End Health Disparities (NPA), a national movement with the mission to improve the effectiveness of programs that target the elimination of health disparities through coordination of leaders, partners and stakeholders who are committed to action. The Heartland RHEC is a coalition of leaders and health disparities experts in Iowa, Kansas, Missouri, and Nebraska. The Heartland RHEC envisions a region free of disparities in health and health care.

¹ If the registration link does not work, please copy the entire link and paste it into your web browser. For webinar-specific questions, contact the moderator at csantos@explorepsa.com.

###

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.

###

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).

###

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](#)

###

If you wish to unsubscribe from future CMS Region 7 emailings, please send an email to Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov with the word “Unsubscribe” in the subject line.