

CMS Region 7 Updates

07/29/2016

ACA/Marketplace Updates

2016 Assister Certification Bulletin Now Available

CMS released the [2016 Assister Certification Bulletin](#) which outlines the Navigator and certified application counselor (CAC) certification and recertification requirements for the 2017 plan year, including the certification training curriculum for the Federally-facilitated Marketplace (FFM). In this bulletin, we refer to this updated training curriculum as the “2017 training.” Similar to last year, the 2017 training will be available through the Marketplace Learning Management System (MLMS). We anticipate that the updated training will be available by mid-July 2016.

Click [here](#) to view the 2016 Assister Certification Bulletin.

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Assister Training Now Live

On Monday, July 11, 2016 CMS launched the 2017 Assister Certification Training hosted on the Marketplace Learning Management System (MLMS); the online web-based training platform for assisters providing application and enrollment assistance to consumers in Federally-Facilitated Marketplaces (FFMs), including State Partnership Marketplaces (SPMs), and certain State-based Marketplaces using the Federal platform (SBM-FPs). The training can be accessed through the CMS Enterprise Portal by logging in or registering as a new user at <https://portal.cms.gov/wps/portal/unauthportal/registration>. Existing users can login at: <https://portal.cms.gov>.

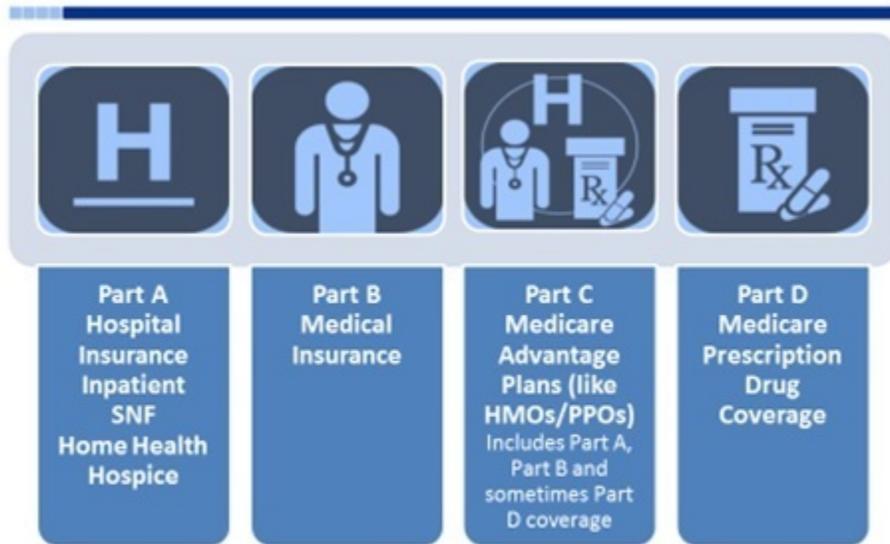
You can find training presentations and additional resources, such as Frequently Asked Questions (FAQs), MLMS Quick Reference Guides, and Help Videos at the following link: <https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html>.

For additional assistance with questions on the MLMS assister training, please submit inquiries to MLMSHelpDesk@cms.hhs.gov. For assistance with CAC program questions, submit inquiries to CACQuestions@cms.hhs.gov. For assistance with Navigator program questions, submit inquiries to your CMS project officer.

For additional information regarding assister training, please use the following resources:

- [Launch of Plan Year 2017 FFM Assister Training – updated July 5, 2016 \(slides\)](#)
- [Quick Reference Guide: Plan Year 2017 FFM Registration and Training Steps for Assistors – updated July 5, 2016](#)
- [Quick Reference Guide: Plan Year 2017 Computer Configuration Requirements – updated July 5, 2016](#)
- [2016 Assister Recertification Bulletin: Guidance Regarding Training, Certification, and Recertification for Navigators and Certified Application Counselors in the Federally-facilitated Marketplaces](#)

Medicare and the Marketplace



Medicare – A short introduction

Medicare is the Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). There are four different parts of Medicare that help cover specific services, including Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), Medicare Part C (Medicare Advantage Plans), and Medicare Part D (prescription drug coverage).

In general, **Part A** covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care, and **Part B** covers certain doctors' services, outpatient care, medical supplies, and preventive services. Medicare Part A and Part B are often referred to as Original Medicare. Medicare **Part C, or a Medicare Advantage Plan**, is a type of Medicare health plan offered by a private company that contracts with Medicare to provide consumers with all of their Part A and Part B benefits. Lastly, Medicare **Part D** adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

Part A: Premium vs. Premium-Free

Most people with Medicare do not pay a Part A premium because they or their spouses paid Medicare taxes while working. These consumers are entitled to what is often referred to as Premium-Free Part A. However, consumers who do not have the required amount of working credit accumulated will need to pay a monthly premium, often referred to as Premium Part A. Enrollment in Premium-Free and Premium Part A meet the requirements for minimum essential coverage (MEC). However, having Medicare Part B alone does not meet the MEC requirement.

Enrolling in Medicare

If a consumer is already getting Social Security or Railroad Retirement Board (RRB) benefits (for example, getting early retirement at least 4 months before turning 65) he or she will automatically be enrolled in Medicare Part A and Part B without an additional application. These consumers will get their Initial Enrollment Period Package, which includes a Medicare card and other information, about 3 months before turning 65 (coverage begins the first day of the month a consumer turns 65), or 3 months before the 25th month of disability benefits (coverage begins on the 25th month of disability benefits).

If the consumer is not getting retirement benefits from Social Security or the RRB, he or she must sign up to get Medicare. Generally, consumers have a seven month initial enrollment period to sign up for Part A and/or Part B when they first become eligible for Medicare. For example, if a consumer becomes eligible when he or she turns 65, the consumer can sign up during the seven month period that begins three months before the month he/she turns 65, includes the month the consumer turns 65, and ends 3 months after the month the consumer turns 65. If a consumer does not sign up for Part A and/or Part B when first eligible, and he or she isn't eligible for a special enrollment period (SEP), the consumer can sign up for Medicare Premium Part A and/or B during the Medicare General Enrollment Period between January 1 - March 31 each year, and may have to pay a penalty for late enrollment. The Part B penalty is a lifetime penalty.

Tips for Helping Consumers with Medicare and the Marketplace:

- Medicare isn't part of the Marketplace
- If the consumer has Medicare he or she is covered and doesn't need to do anything related to the Marketplace
- The Marketplace doesn't offer Medigap or Part D plans
- It's against the law for to sell a consumer a Marketplace plan if they know the consumer has Medicare
 - Even if you only have Part A or Part B
- A consumer can enroll in a Marketplace plan before his or her Medicare coverage begins
 - The consumer should cancel the Marketplace plan when Medicare coverage starts, or
 - The consumer may keep the plan, but once Medicare Part A coverage starts **the consumer will not be able to get lower costs , such as Premium Tax Credits for their Marketplace plan**
- Consumers should sign up for Medicare during their Initial Enrollment Period
 - If he or she enrolls later, **he or she may have to pay a late enrollment penalty for as long as he or she have Medicare**
- A consumer can't choose Marketplace coverage over Medicare unless
 - The consumer pays or would have to pay a Part A premium
 - In this case, a consumer can drop Part A and B and may be eligible to get a Marketplace plan
 - The consumer has a medical condition that qualifies him or her for Medicare (like ESRD) but haven't applied for Medicare
 - The consumer is not yet collecting Social Security retirement or disability benefits before you're eligible for Medicare
- In your work with this population, don't forget to refer Medicare eligible consumers to [SHIP counselors](#) to assist with their Medicare enrollment and help consumers determine if they are eligible for programs to help pay for Medicare coverage such as Medicare Savings Plans.

Click [here](#) for more information on Medicare and Marketplace

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Helping Consumers with Appeals

As a reminder, assisters may help consumers [appeal unfavorable Marketplace decisions](#). Below are some examples of the kinds of appeals assistance that assisters can provide:

1. Helping consumers understand that they have a right to appeal eligibility determinations made by the Marketplace (including SHOP) related to enrollment in a QHP, special enrollment periods, exemptions from the individual shared responsibility payment that are granted by the Marketplace, or participation as an employer in a SHOP. In addition, assisters can help consumers appeal eligibility determinations made by the Marketplace related to insurance affordability programs, including eligibility determinations for Marketplace financial assistance, Medicaid, and the Children's Health Insurance Program;
2. Helping consumers identify and meet the deadline for appealing a Marketplace eligibility determination;

3. Helping consumers understand the process of appealing those eligibility determinations and what steps to take to complete an appeal;
4. Helping consumers access relevant Marketplace resources, such as appeal request forms and mailing addresses for appeals, and Marketplace guidance on appeals;
5. Providing consumers with information about free or low-cost legal help in their area, including local legal aid or legal services organizations and other State offices to help with the Marketplace eligibility appeals process;
6. Helping consumers collect supporting documentation for the appeal (such as screenshots of relevant information from the online application).

The Difference Between Appeals Assistance and Legal Advice

Remember that when you're acting as an assister, you should not give consumers legal advice, such as recommending that consumers take specific action with respect to their appeal rights. For example, you can help consumers understand the difference between an appeal and an expedited appeal, but should not advise them to pick one over the other. This is similar to the way assisters should not advise consumers to pick a specific plan, but instead provide consumers with enough information that they can pick the plan that best suits their needs.

This also means that although assisters are not prohibited from serving as authorized representatives altogether, they should not serve as authorized representatives *in their assister capacity*. Assisters should keep any activities as a consumer's authorized representative separate from their assister duties and should not use Navigator grant funds for this purpose.

- For example, if a staff member's position is funded by multiple grants, she can charge her authorized representative work to another grant and explain to consumers that this assistance is not part of her assister work.
- Another option is to designate someone else in the organization who is not an assister to act as consumers' authorized representative.

Note that being an authorized representative is different from serving as a *third-party representative for the Marketplace Call Center or communicating on a consumer's behalf with a state Medicaid office*. For Call Center purposes only, a consumer can designate someone (including an assister) as a third-party representative to communicate with the Marketplace Call Center on the consumer's behalf. This is not the same as a formal designation of an authorized representative, which occurs when a consumer chooses someone to act, rather than only communicate, on his or her behalf during interactions with the Marketplace. Instead, this designation allows assisters to facilitate communication with the Call Center for a consumer when the consumer otherwise cannot communicate or chooses not to communicate with the Call Center herself.

Tips for helping consumers with appeals:

- When working with consumers who have filed a Marketplace appeal, please advise them to retain their assigned appeal number (APL #).
- You can help consumers track their appeal by telling them to call the Marketplace Appeals Hotline (855-231-1751) to check on the status of their appeal.

2016 Employer Notices and Appeals

Key Takeaway: An employer may receive an "Employer Notice" if its employee enrolled in Marketplace coverage with Advanced Premium Tax Credits (APTCs) or Cost Sharing Reductions (CSRs) in 2016 and the employee attested that he or she did not have

an offer of affordable coverage from his or her employer that meets the minimum value standard. This notice gives the employer the right to appeal to the Marketplace and demonstrate that it did offer its employee affordable employer-sponsored coverage (ESC) that meets the minimum value standard. Employees have the right to participate in the appeal process and present evidence. Assistants can help employees understand this notice and their rights.

Employer Notices

The Marketplace “Employer Notice” notifies employers when an employee enrolled in coverage with APTC and if applicable, CSRs and the employee attested that he or she:

- didn’t have an offer of health care coverage;
- did have an offer of health care coverage, but it wasn’t affordable or didn’t provide minimum value; or
- was in a waiting period and unable to enroll in health care coverage.

The notice informs the employer that, if various conditions are met, IRS may assess an employer shared responsibility payment from the employer. IRS ultimately decides which employers will be assessed the penalty. Only certain employers (including those with at least 50 full-time employees or full-time equivalent employees – called applicable large employers) are subject to the employer shared responsibility payment assessed by the IRS.

The Marketplace sends Employer Notices regardless of employer size (or other criteria on which IRS would base the assessment of the penalty). This is because an employee who enrolls in Marketplace coverage with APTC and if applicable, CSRs could face a tax liability for receiving APTC in any month in which the employee has an offer affordable ESC that meets the minimum value standard.

Employer Appeals

An employer that receives an Employer Notice has the right to file an appeal to the Marketplace on the grounds that it did offer its employee affordable ESC that meets the minimum value standard. An employee will be notified if its employer appeals and will be given the opportunity to submit evidence.

Example: An employee can submit income information such as pay stubs to demonstrate that the ESC plan was not affordable. An employee can also provide the Summary of Benefits and Coverage (SBC) Sheet from their ESC plan to show it does not meet minimum value standards.

An employee will not be notified if an employer does not receive an Employer Notice or does not file an appeal in response to an Employer Notice. **Note:** In 2016, the Marketplace will only send Employer Notices when it has valid employer addresses, so some employers may not receive a notice.

The Marketplace appeals entity for the Federally Facilitated Marketplace will send both the employer and the employee a notice with information about the outcome of the appeal:

- If the Marketplace appeals entity finds that the employer did provide affordable, minimum value ESC, the employee will receive a notice explaining the decision with instructions to update his or her application for Marketplace coverage to reflect that he or she has an offer of affordable, minimum value employer-sponsored coverage. As a result, once the employee updates his or her Marketplace application, the employee may be determined ineligible for APTC and CSRs going forward. This is intended to protect the employee from the possibility of increased tax liability that can result when an employee has an offer of affordable ESC that meets the minimum value standard and Marketplace coverage with APTC and if applicable, CSRs.
- If the Marketplace appeals entity finds that the employer did not provide affordable, minimum value ESC, the employee will receive a notice explaining the decision and the employee’s eligibility for APTC and if applicable CSRs will remain the same going forward.

Regardless of the appeal decision, the IRS will conduct its own independent process to determine if the employer is liable for the employer shared responsibility payment. IRS is also responsible for determining when a consumer is liable to repay APTC at tax filing.

Remember, it's a violation of the Fair Labor Standards Act to discriminate against any employee because he or she received APTC or CSRs. An employee who believes he or she has been discriminated against can file a complaint with the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) Whistleblower Protection Program.

Additional Resources

Sample Employer Notice: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Employer-Initiatives/Downloads/Final-Notice-for-Posting-05_10_2016.pdf

Marketplace Employer Appeal Process: <https://www.healthcare.gov/marketplace-appeals/employer-appeals/>

U.S. Dept. of Labor, OSHA Whistleblower Protection Program:
<https://www.osha.gov/Publications/whistleblower/OSHAFS-3641.pdf>

###

2016 Marketplace Enrollment Manual

- Today, CMS released an updated version of the Marketplace enrollment manual, which provides operational policy and guidance for eligibility and enrollment activities within the Federally-facilitated Marketplaces (FFMs), the Federally-facilitated Small Business Health Options Programs (FF-SHOPs) and to State-based Marketplaces and SHOPs that use the federal eligibility and enrollment platforms (SBMs-FP).
- Topics covered include, but are not limited to, initial open enrollment periods and effective dates, premium payment, direct enrollment, special enrollment periods, and enrollment terminations.
- To access the manual, visit: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR-FFM-SHOP-Manual-071916.pdf>

###

Resources for Agents and Brokers Webpage

The [Resources for Agents and Brokers webpage](#) is your primary source of information about FFM registration and the plan year 2017 Open Enrollment period, and to help you assist consumers in enrolling in and using their Marketplace health plans. See the webpage for these recent updates:

- [“Agent and Broker Guide to the Immigration Section of the Online Marketplace Application.”](#) This guide provides step-by-step instructions and screenshots that illustrate how to: verify identity and citizenship or immigration status on the Marketplace application, complete enrollment in a Marketplace plan, and determine or assess potential eligibility for Medicaid or the Children’s Health Insurance Program. The guide also contains a list of frequently asked questions on issues that commonly arise when helping non-citizen consumers.
- [“Special Enrollment Periods \(SEPs\): Overview for the Federally-facilitated Marketplaces \(FFMs\).”](#) (webinar slides) The June 28 webinar provided overview of the SEP process, include examples of life events that could qualify consumers for an SEP, and explain how consumers can use an SEP to get health coverage.
- [“Special Enrollment Confirmation Process.”](#) (webinar slides) The June 29 webinar explained how agents and brokers can help consumers respond to the new requirement that consumers provide documents to verify their eligibility for certain SEPs.

###

Marketplace Fraud Reminder

It's important to help consumers differentiate between legitimate requests for additional information from the Marketplaces and fraudulent phishing attempts from scammers to access consumers' private information. As the Marketplace addresses, Special Enrollment Period verification, and application "inconsistencies" or "data matching issues" for consumers' applications for health coverage, some consumers will be asked to provide additional information to verify the data entered on their application. In some cases, the Marketplace may call a consumer directly to request the consumer provide more information that will help resolve application inconsistencies.

Help consumers identify legitimate Marketplace requests by reviewing and sharing the following resources:

- [Protect yourself from Marketplace fraud](#) (Tips, Marketplace outbound phone numbers, when to report suspected fraud)
- [Avoid Email Phishing Attempts](#)
- [Healthcare and Marketplace Related Scam Indicators](#)
- [Latest Health related Scam Alerts](#)
- [What to do if your information is lost or exposed](#)

###

Auto Re-enrollment for QHPs No Longer Available in the Marketplace-FAQs

On June 24, 2016 the Centers for Medicare & Medicaid (CMS) released a Frequently Asked Question (FAQ) stating that if no Qualified Health Plans (QHPs) from the same issuer are available through the Marketplace, then the Marketplace could automatically re-enroll enrollees into QHPs from different issuers. Such auto re-enrollments would be directed by the applicable State regulatory authority, or, where the applicable State regulatory authority declines to act, by the Marketplace. This is the first year that we are implementing this renewal operation in the FFM.

Click [here](#) to view the FAQs on auto re-enrollment for QHPs no longer available in the Marketplace.

###

Healthcare.gov Cost Sharing Data Brief

CMS released a new data brief showing that the median individual deductible for HealthCare.gov Marketplace policies (after taking into account cost-sharing reductions) in 2016 is \$850, down from \$900 in 2015. The brief touches on several key data points that reflect the accessibility and financial protection Marketplace plans provide. These findings are for the 8.4 million consumers insured through states using the federal eligibility and enrollment platform.

To read the **data brief**, visit: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html

###

2016 State-Based Marketplace Public Use Files

In an effort to facilitate greater access to Marketplace data, CMS released a set of state-based Marketplace public use files (SBM PUF). Each file contains data associated with certified qualified health plans (QHPs) and stand-alone dental plans (SADPs) within state-operated Marketplaces.

While health plan information including benefits, copayments, premiums, and geographic coverage is publically available on HealthCare.gov, these downloadable files on the other hand, will help researchers and other stakeholders conduct timely benefit and rate analysis.

With that, the SBM PUF is comprised of the following 2016 Data Dictionaries:

- Benefits and Cost Sharing PUF – Plan-level data on essential health benefits, coverage limits, and cost sharing.
- Rate PUF – Plan-level data on individual rates based on an eligible subscriber’s age, tobacco use, and geographic location.
- Plan Attributes PUF – Plan-level data on maximum out of pocket payments, deductibles, cost sharing, HSA eligibility, formulary ID, and other plan attributes.
- Business Rules PUF – Additional information on how an issuer determines the premiums for a specific application. For example: the maximum number of dependents used to determine a family rate for single or two parent families, the maximum age for a dependent, whether a domestic or same sex partner may be treated as a spouse, Number of tobacco-free months considered when qualifying for a non-tobacco rate.
- Service Area PUF – Issuer-level data on the geographic coverage or service area (i.e., where the plan is offered) including state, county, and zip code.
- Network – Issuer-level data identifying provider network URLs.

To download the files, visit: <https://www.cms.gov/CCIIO/Resources/Data-Resources/sbm-puf.html>

###

Annual Income Threshold FAQ

As part of our ongoing effort to improve the consumer experience in the Marketplace, CMS is implementing a change that will allow more consumers to get their household income immediately verified by the Marketplace when they submit an application. The change will reduce the number of consumers that have to follow-up and submit documentation to verify their household income while maintaining important program integrity controls. These FAQs provide details about this change in the Marketplace, as well as guidance on what this means for State-Based Exchanges.

For more information, see the FAQ on CCIIO’s website here: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-Income-Datamatching-FAQ-7-21-16.pdf>

###

DATA Highlight: Health Disparities Experienced among Older Sexual Minorities: National Health

Interview Survey, 2013–2014

The Office of Minority Health at the Centers for Medicare and Medicaid Services (CMS OMH) posted online national data – for the first time ever - exploring differences in 15 health characteristics between adults 65 years of age or older (older adults) who self-identify as lesbian, gay, or bisexual (sexual minority), and older adults who identify as heterosexual or straight (sexual majority).

This data present estimates using data from two years of the National Health Interview Survey (NHIS 2013-2014) conducted by the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) showing statistically significant differences for several health characteristics between sexual minority and sexual majority respondents.

For more details and key finding of the survey click here: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight-Health-Disparities-Among-Older-Sexual-Minorities-06-2016.pdf>

The Office of Minority Health at the Centers for Medicare and Medicaid Services is committed to supporting the departments' goals and to advancing sexual orientation and gender minority data collection and research.

###

Healthcare.gov Cost Sharing Data Brief

Today, CMS released a new data brief showing that the median individual deductible for HealthCare.gov Marketplace policies (after taking into account cost-sharing reductions) in 2016 is \$850, down from \$900 in 2015.

To read the **data brief**, visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html> *

To read the **press release**, visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-07-12.html> *

***NOTE: These links are still delayed but we hope to have them live soon. Sorry for this inconvenience.**

Please help us to amplify these important findings on social media using any of the below **sample tweets**:

- 7...the avg number of covered services Marketplace consumers have with no or low cost sharing [LINK]
- REPORT: Marketplace plans are providing consumers with real \$\$ protections & access to important health services [LINK]
- Median Marketplace deductible (amount you pay for certain services before insurance kicks in) is \$850. #ACAWorks [LINK]
- 1/3 of HealthCare.gov Marketplace enrollees have deductibles less than or equal \$250 in 2016 [LINK]
- Over 50% of Marketplace consumers have deductibles below \$1000 in 2016 [LINK]
- Most Marketplace plans cover primary care visits, generic drugs with no or low cost sharing [LINK]
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###

Agent and Broker Guide to the Immigration Section of the Online Marketplace Application” Now Available

This guide will help you assist consumers with completing the citizenship and immigration questions of the online Marketplace application. It provides step-by-step instructions and screenshots that illustrate how to: verify identity and citizenship or immigration status; submit supporting documentation, if requested; complete other steps necessary for enrollment in a QHP through the Marketplace; and determine or assess potential eligibility for Medicaid or the Children’s Health Insurance Program. The guide also contains a list of frequently asked questions on issues that commonly arise when helping non-citizen consumers. For more information, you can review the document [here](#).

###

Small Business Health Operations Program (SHOP) Marketplace Corner: There is No Time Like the Present – Enroll Consumers in SHOP Marketplace Coverage Today

Small employers with one to 50 employees can apply and enroll in health insurance through the SHOP Marketplace at any time. There is no limited enrollment period. Small employers can begin to offer coverage in any month of the year. Applications that are submitted before the 15th of the month can go into effect as soon as the first day of the following month. Applications submitted after the 15th of the month can go into effect as soon as the first day of the second following month.

HealthCare.gov also offers a variety of tools to help you and consumers get started:

- [See Plans and Prices](#): Help consumers browse SHOP Marketplace health and dental plans available in their areas before they enroll.
- [Full-time Equivalent \(FTE\) Calculator](#): Help consumers determine if they are eligible for SHOP Marketplace coverage by counting their total number of FTE employees.
- [Tax Credit Estimator](#): Help consumers determine whether they may be eligible for the Small Business Health Care Tax Credit, available exclusively through the SHOP Marketplace, and estimate how much the tax credit may be worth to employers.
- [Minimum Participation Rate \(MPR\) Calculator](#): Help consumers predict whether they meet the MPR in their state to participate in the SHOP Marketplace

Need assistance? The SHOP Call Center is available to assist agents, brokers, employers, and employees with an offer of SHOP Marketplace coverage, Monday – Friday 9:00 AM – 7:00 PM ET at 1-800-706-7893 (TTY: 711).

###

Migration of the Agent and Broker Federally-facilitated Marketplace (FFM) Registration Completion List (RCL) to Data.HealthCare.gov

Starting July 18, 2016 both the Agent and Broker Federally-facilitated Marketplace (FFM) Agent and Broker Registration Completion List (RCL) and the Agent and Broker FFM Registration Termination List files will be upgrading to the [Data.HealthCare.gov](#) platform.

These lists will be updated as frequently as daily. Access to the newly migrated FFM lists will be available through the [Agents and Brokers Resources webpage](#) in the registration status lists section. Agents and brokers can review the RCL to confirm if you have completed registration and are authorized to assist consumers in selecting qualified health plans through the FFMs.

###

Spotlight on Eligibility and Enrollment: Reducing the Impact of Data Matching Issues

To ensure consumers are eligible for Marketplace coverage and financial assistance, CMS verifies eligibility for most consumers through electronic trusted data sources. However, if consumers' data cannot be matched electronically, CMS generates a data matching issue to request additional information from them. Consumers who do not provide the necessary information will have their coverage or financial assistance ended or modified. Unfortunately, eligible consumers sometimes lose coverage or financial assistance through the Marketplace because they are unable to locate documents or navigate the data matching process.

You can learn more about some of the improvements CMS has made to make sure consumers who are eligible for and need coverage throughout the year are able to stay covered from the [Keeping Consumers Covered](#) post by Kevin Counihan, the Chief Executive Officer of the Center for Consumer Information & Insurance Oversight (CCIIO) and Health Insurance Marketplace Director.

###

Article by President Obama in the Journal of the American Medical Association on his assessment of the Affordable Care Act (ACA)

Today, the *Journal of the American Medical Association (JAMA)* published an article authored by the President on his assessment of the Affordable Care Act (ACA). The article reviews the factors influencing the President's decision to pursue health reform, summarizes evidence on the effects of the law to date, recommends actions that could build on the progress we've made under the law to improve our health care system, and identifies general lessons for current and future policymakers.

This article is the culmination of a review of the ACA's performance that started more than six months ago at the President's request, examining areas in which the law has been successful and in which it could be further strengthened to ensure all Americans have access to quality, affordable health care.

The President presents evidence in *JAMA* demonstrating the ways the law is working. This includes: sharply increasing insurance coverage and greatly improving coverage for those who already had it, which is improving Americans' access to care, financial security, health and well-being; and shifting our health care system toward one that rewards doctors and hospitals for delivering efficient, high-quality care to patients, which has helped reduce hospital readmissions and deaths from hospital-acquired conditions and helped lower Medicare and private-sector health care spending.

Despite this significant progress, the President recognizes that more work is necessary to ensure every American can afford health care and navigate a complex health system. That's why he offered five suggestions on how to do so:

- **Stay the course:** Policymakers should build on the ACA's successful framework by encouraging the remaining 19 states to expand Medicaid and continuing ongoing efforts to reform the health care delivery system, while maintaining bipartisan support for Precision Medicine, the BRAIN Initiative and the Cancer Moonshot.
- **Increase financial assistance to purchase health insurance:** Because some individuals still report being unable to afford coverage, Congress should provide increased financial assistance to purchase coverage. The ACA's coverage provisions are projected to cost 28 percent less than original Congressional Budget Office projections, providing an opportunity to reinvest these savings to make coverage even more affordable while keeping costs below initial projections.
- **Add a public plan option in areas of the country lacking competition:** While the vast majority of Americans live in areas where there's competition in the Health Insurance Marketplace, some parts of the country have long struggled with limited insurance market competition and continue to do so. That's why the President urges Congress to revisit legislation to allow a public plan to compete alongside private insurers in areas of the country where competition is limited.

- **Address prescription drug costs:** The increasing costs of prescription drugs are a major concern for Americans, employers, and taxpayers alike. Congress should act on proposals to lower the cost of prescription drugs, like the ones included in the President’s budget.
- **Avoid moving backward:** The time spent by Republicans on more than 60 attempts to repeal parts of all of the ACA could have been better spent working to improve our health care system and economy.

Finally, the President offers some lessons to current and future policymakers that he learned from his experience: that any change is difficult, especially when facing hyperpartisanship; that special interests pose a continued obstacle and we must continue to tackle them, and that pragmatism is of the utmost importance in both legislation and implementation. But most importantly, that the President’s experience with the ACA makes him optimistic about America’s capacity to make meaningful progress on even the biggest public policy challenges. As progress on health reform demonstrates, faith in responsibility, belief in opportunity, and ability to unite around common values are what makes this nation great.

The *JAMA* article is attached here and will be available at this link beginning at 5PM EDT:
><http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2016.9797><

###

New Marketplace Data Products Available on CMS.gov

CMS recently released new public use files with data on enrollment in the Health Insurance Marketplaces. These new data products are available on the Marketplace Products webpage at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html>. CMS created this webpage to serve as an easy-to-use resource to find Marketplace information products and analytics and will update this page with new Marketplace data products as they are developed.

The following data products are currently available for download:

- 2016 Marketplace Health Plan Selections by County: The total number of health plan selections by county for the 38 states that use the HealthCare.gov platform, as well as county-level plan selection information by age, race/ethnicity, Federal Poverty Level, metal level, Cost-Sharing Reduction, and Applied Premium Tax Credit.
- 2014, 2015, and 2016 Quarterly Effectuated Enrollment Snapshots by State: The total number of consumers with effectuated Marketplace coverage in all 50 states and Washington, DC as well as information on metal level, Cost-Sharing Reduction, and Applied Premium Tax Credit.

###

Issuer Insights & Innovation in Marketplace Year 3

On June 9th, 2016, the Marketplace Year 3: Issuer Insights and Innovation conference took place in Washington, D.C. In addition to remarks from CMS Acting Administrator Andy Slavitt and HHS Secretary Burwell, presentations were made by Marketplace issuers from all regions of the country describing the innovations they have made to find patients, engage them in improving their health, and provide services that meet consumer needs.

All materials from the Issuer Insights and Innovation forum are now available on the CCIIO website. Please visit [here](#) to access the final agenda, including remarks from Andy Slavitt, and Secretary Burwell, slides from each session, and a video of the entire day's event.

Also, On June 8th, 2016, The CMS Blog published [Marketplace Success Stories](#), which shares some of the specific innovations and strategies employed by Marketplace issuers in order to provide consumers with health plans that are compatible with their medical needs and household budgets.

###

ASPE Issue Brief: Promoting Better Health for Women

The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) released [The Affordable Care Act: Promoting Better Health for Women](#), an issue brief that illustrates in three sections how the provisions of the ACA have expanded coverage for women through the law's core tenets of access, affordability, and quality.

###

Reducing the Impact of Data Matching Issues

As assisters have observed, the Marketplace verifies eligibility for most consumers through electronic trusted data sources, but if consumers' data cannot be matched electronically we generate a data matching issue to request additional information from enrollees. Consumers who do not provide the necessary information will have their coverage or financial assistance ended or modified.

This year, CMS made a [range of improvements](#) to the data matching process to help consumers avoid generating data matching issues in the first place and to help them resolve these issues once generated. More recently, we have also intensified our outreach and partnered with issuers so that they are reaching out to consumers about data-matching issues as well. These efforts are beginning to pay off, with a sharp reduction in total data-matching issues generated and an almost 40 percent year-over-year increase in the number of documents consumers have submitted to resolve these issues. Continued progress in this area should benefit both directly affected consumers and other consumers who will benefit from a stronger risk pool.

###

Strengthening the Marketplace by Covering Young Adults

On June 21, 2016, CMS released a [Fact Sheet](#) titled: Strengthening the Marketplace by Covering Young Adults, subtitled Deploying New Targeting Strategies and Partnerships to Reach Young Adults and Others Who Are Still Uninsured.

The Fact Sheet covers new strategies for the 2017 Open Enrollment, such as preventing young adults from losing coverage as they age out of Medicaid and CHIP and their parents' health plans, and working with partners to reach young adults where they already are. Assisters can use this as a resource as they plan their outreach and enrollment efforts for the 2017 Open Enrollment Period. To read more about this initiative, click [here](#).

###

Impact of ACA Coverage Expansion on Rural and Urban Populations

On June 10th, the U.S. Department of Health and Human Services released an issue brief that analyzes how the Affordable Care Act has benefited rural America. The findings, which examine independent studies and other data, show that health coverage in rural counties increased by 8.0 percentage points between late 2013 and early 2015, and the share of rural Americans unable to afford needed care dropped by almost six percentage points during this same time period.

This ASPE report documents the success of the Health Insurance Marketplace in particular in expanding coverage and access to care in rural areas. The press release may be read [here](#), and you may read the issue brief in its entirety [here](#).

###

CMS Announces \$32 Million to Increase Number of Children with Quality, Affordable Health Coverage

On June 13, 2016, CMS announced that \$32 Million will be awarded to 38 community organizations in 27 states to support targeted strategies intended to enroll eligible children in Medicaid and CHIP as part of the Connecting Kids to Coverage campaign. The awardees include states, school districts, and local community organizations from across the country in areas where access to coverage has been lagging, and targets American Indians, children with learning disabilities, rural communities, and teens.

To see the press release in its entirety, click [here](#).

###

CMS Announces \$22 Million in ACA Funding for State Insurance Departments

On June 15, 2016, CMS announced the availability of \$22 million in funding that will be distributed to state insurance regulators to increase the compliance of issuers with ACA consumer protections and to help support the efforts of State Departments of Insurance to ensure that their own laws and regulations are compatible with Federal requirements and for states to oversee and enforce these provisions of the ACA that provide important consumer protections. Read the Press Release in its entirety [here](#).

###

Effectuated Enrollment Snapshot: 11.1 Million Enrolled

On June 30, 2016, the CMS announced that more than 11.1 million consumers effectuated Marketplace coverage as of March 31, 2016. In other words, more than 11.1 consumers paid their premiums and were enrolled in an active policy at the end of March 2016. This is an increase of almost a million more consumers than were enrolled at the end of the first quarter of 2015.

To see the fact sheet in its entirety, including tables that show the levels of enrollment, financial assistance, tax credits and metal level of plans by state, click

###

School-Based Outreach and Enrollment Toolkit Available

The Connecting Kids to Coverage National Campaign is excited to share a new resource we've developed to help bridge relationships between schools and organizations. Our new School-Based Outreach and Enrollment Toolkit is available for download today at: go.cms.gov/back2school.

We've developed this guide to partnering with schools to enroll eligible children in Medicaid and the Children's Health Insurance Program. The Toolkit highlights strategies for integrating enrollment into existing school processes—like including enrollment questions on new student registration forms—and developing sustainable outreach partnerships. It also includes tips for identifying and working with different members of the school community from nurses and school social workers to principals and superintendents. In addition, the Toolkit includes template communication tools such as:

- Social media posts
- Newsletter and website copy
- Press release and media advisory
- Radio PSA scripts
- Outreach calendar

In other exciting news, CMS recently awarded \$32 million in funding to help 38 community organizations in 27 states enroll eligible children in Medicaid and CHIP as part of the Connecting Kids to Coverage National Campaign. These awards, provided by the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) legislation, are designed to build on the historic progress already made in increasing the number of children who have health coverage and to reach and enroll the remaining uninsured children. To see a list of these organizations, visit: www.insurekidsnow.gov/downloads/initiatives/grantsummary-2016.pdf

###

SUMMARY REPORT ON TRANSITIONAL REINSURANCE PAYMENTS AND PERMANENT RISK ADJUSTMENT TRANSFERS FOR THE 2015 BENEFIT YEAR

Today, the Centers for Medicare and Medicaid Services (CMS) issued the Summary Report on Transitional Reinsurance Payments and Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year. The report includes summary level and issuer level data related to risk adjustment transfers and reinsurance payments for the 2015 benefit year.

For more information, click here: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf>

###

March 31, 2016 Effectuated Enrollment Snapshot

On March 31, 2016, about 11.1 million consumers had effectuated Health Insurance Marketplace coverage – which means those individuals, paid their premiums and had an active policy as of that date. HHS continues to project effectuated enrollment of about 10 million people for the end of 2016.

Of the approximately 11.1 million consumers nationwide with effectuated Marketplace enrollments at the end of March 2016, about 85 percent, or about 9.4 million consumers, were receiving an advance payment of the premium tax credit (APTC) to make their premiums more affordable throughout the year. The average APTC for those enrollees who qualified for the financial assistance was \$291 per month.

There were 8.4 million consumers with effectuated enrollments at the end of March 2016 through the 38 Federally-Facilitated Marketplaces, including State Partnership Marketplaces and State-based Marketplaces that utilize the HealthCare.gov eligibility and enrollment platform (SBM-FPs), collectively known as HealthCare.gov states and 2.7 million through the remaining State-based Marketplaces.

As of the end of March 2016, about 11.1 million people had health insurance coverage through the Health Insurance Marketplaces, almost a million more than at this point in time a year ago. “This increased level of enrollment demonstrates the strength of the Marketplace over time, as millions of Americans continue to have access to quality and affordable coverage when they need it. As of early this year, 20 million Americans had coverage thanks to provisions of the Affordable Care Act, and the Health Insurance Marketplace is an important contributor to that progress,” said Kevin Counihan, CEO of the Health Insurance Marketplace.

March effectuated enrollment equaled 87 percent of total Open Enrollment plan selections, within the 80-90 percent range that Marketplace issuers have consistently anticipated and the same percentage as last year, despite factors that might have been expected to lower the percentage. For example, a higher proportion of consumers this year signed up for January 1 coverage, creating a longer window between their initial plan selection and March in which they could have gained employer or other coverage.

To date, CMS has released Marketplace state-by-state effectuated enrollment snapshots on a quarterly basis, detailing how many consumers have an effectuated enrollment, how many are benefiting from financial assistance, and the distribution of effectuated enrollment by qualified health plan metal level. Changes in effectuated enrollment are influenced by many factors and vary from quarter to quarter, and have been reported based on data gathered by the original payment systems set up when the Marketplace launched.

The Marketplace effectuated enrollment snapshot provides point-in-time estimates. CMS expects enrollment numbers will change over time as consumers find other coverage or experience changes in life circumstances such as employment status or marriage, which may cause consumers to change, newly enroll in, or terminate their plans.

Moving forward, CMS will be reporting effectuated enrollment data semiannually, once for the first six months of the year and once for the full twelve months of the year, based on the average number of effectuated enrollments over the relevant time period. Average effectuated enrollment provides a more meaningful metric of Marketplace participation, since it captures all enrollments over the time period, rather than only enrollment at a particular point in time. The new reporting will also facilitate comparisons to projections made by the Congressional Budget

Office, which reflect average enrollment throughout the year. As issuers fully transition to a new payment system using policy-based data, rather than issuer-aggregated workbook-based reporting, the new payment system offers the opportunity to conduct more refined enrollment reporting. We expect to issue the first semiannual effectuated enrollment report in the fall.

Along with this effectuated enrollment report, we are also releasing an addendum (below) providing updated data on special enrollment period activity in 2015, as well as an analysis of the reduction in the number of consumers experiencing coverage terminations or adjustments to financial assistance due to unresolved data-matching issues.

The following tables are included in the March 2016 Marketplace Effectuated Enrollment Snapshot:

Table 1: March 31, 2016 Total Effectuated Enrollment and Financial Assistance by State

Table 2: March 31, 2016 Average Advance Payment of Tax Credits by State

Table 3: March 31, 2016 Total Effectuated Enrollment Data by Metal Level by State

March 2016: Total Effectuated Enrollment and Financial Assistance

Of the approximately 11.1 million consumers who had effectuated Marketplace enrollments at the end of March 2016, about 85 percent or about 9.4 million consumers were receiving APTC and 57 percent or nearly 6.4 million consumers were benefiting from cost sharing reductions (CSRs) to make their coverage more affordable. CSRs are generally available if a consumer’s household income is between 100 percent and 250 percent of the Federal Poverty Level (FPL), the consumer is otherwise eligible for APTC, and the individual chooses a health plan from the silver plan category.

The ten states with the highest rate of consumers who received financial assistance through APTC were: Mississippi (94.2%), Florida (93.3%), Louisiana (92.6%), Wyoming (92.0%), Alabama (91.9%), North Carolina (91.5%), South Carolina (91.0%), Alaska (90.1%), Nebraska (89.9%), and Arkansas (89.7%). The states with the lowest rate of consumers who received APTC are: District of Columbia (6.9%), New York (55.3%), Colorado (61.9%), New Hampshire (63.4%), Minnesota (63.8%), New Mexico (68.9%), Arizona (69.3%), Washington (69.8%), Vermont (70.2%), and Oregon (72.8%).

Table 1: March 31, 2016 Total Effectuated Enrollment and Financial Assistance by State

March 31, 2016					
Total Effectuated Enrollment and Financial Assistance by State					
State	Total Enrollment	APTC Enrollment	Percentage of Enrollment with APTC	CSR Enrollment	Percentage of Enrollment with CSR
Total	11,081,330	9,389,609	84.7%	6,353,551	57.3%
Alabama	165,534	152,206	91.9%	125,424	75.8%

Alaska	17,995	16,205	90.1%	7,500	41.7%
Arizona	179,445	124,346	69.3%	94,463	52.6%
Arkansas	63,357	56,843	89.7%	36,134	57.0%
California	1,415,428	1,239,893	87.6%	707,671	50.0%
Colorado	108,311	67,062	61.9%	28,929	26.7%
Connecticut	102,917	80,759	78.5%	52,132	50.7%
Delaware	25,379	21,467	84.6%	11,146	43.9%
District of Columbia	17,666	1,224	6.9%	279	1.6%
Florida	1,531,714	1,428,712	93.3%	1,125,850	73.5%
Georgia	478,016	427,353	89.4%	322,348	67.4%
Hawaii	13,313	10,958	82.3%	8,067	60.6%
Idaho	94,270	82,802	87.8%	58,781	62.4%
Illinois	335,243	259,701	77.5%	156,469	46.7%
Indiana	168,884	139,437	82.6%	77,251	45.7%
Iowa	48,949	42,595	87.0%	25,677	52.5%
Kansas	89,566	75,815	84.6%	53,034	59.2%
Kentucky	74,640	56,488	75.7%	32,186	43.1%
Louisiana	184,403	170,806	92.6%	118,597	64.3%
Maine	75,240	63,896	84.9%	42,880	57.0%
Maryland	135,208	100,844	74.6%	72,175	53.4%
Massachusetts	207,121	157,751	76.2%	132,721	64.1%
Michigan	313,123	275,080	87.9%	164,725	52.6%
Minnesota	74,060	47,266	63.8%	12,128	16.4%
Mississippi	77,747	73,246	94.2%	60,354	77.6%
Missouri	252,044	225,878	89.6%	148,033	58.7%
Montana	51,758	44,091	85.2%	23,479	45.4%
Nebraska	80,213	72,091	89.9%	41,950	52.3%
Nevada	79,876	71,472	89.5%	48,736	61.0%
New Hampshire	49,114	31,151	63.4%	17,376	35.4%
New Jersey	249,395	205,242	82.3%	129,277	51.8%
New Mexico	47,497	32,703	68.9%	22,655	47.7%
New York	224,014	123,830	55.3%	40,544	18.1%
North Carolina	545,354	499,178	91.5%	360,045	66.0%
North Dakota	20,536	17,630	85.8%	9,199	44.8%
Ohio	212,046	174,448	82.3%	95,312	44.9%
Oklahoma	130,178	113,209	87.0%	81,053	62.3%
Oregon	131,167	95,507	72.8%	52,960	40.4%
Pennsylvania	412,347	321,345	77.9%	227,304	55.1%

Rhode Island	35,583	30,015	84.4%	21,270	59.8%
South Carolina	204,846	186,345	91.0%	150,030	73.2%
South Dakota	24,578	22,005	89.5%	15,108	61.5%
Tennessee	231,705	203,112	87.7%	138,272	59.7%
Texas	1,092,650	913,177	83.6%	646,415	59.2%
Utah	164,415	145,288	88.4%	106,589	64.8%
Vermont	27,883	19,575	70.2%	9,751	35.0%
Virginia	378,838	319,068	84.2%	222,233	58.7%
Washington	158,245	110,476	69.8%	66,083	41.8%
West Virginia	33,235	29,163	87.7%	17,414	52.4%
Wisconsin	224,208	190,542	85.0%	123,307	55.0%
Wyoming	22,076	20,313	92.0%	12,235	55.4%

March 2016: Average APTC by State

Consumers with household incomes between 100 percent and 400 percent of the FPL may qualify for APTC, which helps make their coverage more affordable throughout the year by lowering their share of monthly premium costs. Consumers who qualify for APTC may choose how much of the APTC to apply to their premiums each month, up to the maximum amount for which they are eligible.

The overall average APTC Marketplace consumers received was \$291 per month at the end of March 2016. Because the amount of APTC an enrollee may receive depends on household income and the cost of the second lowest cost Silver plan available to the enrollee, the average APTC ranged from \$750 per month in Alaska to \$178 per month in New York.

Table 2: March 31, 2016 Average Advance Payment of Tax Credits by State

March 2016 Average Advanced Premium Tax Credit by State (for individuals receiving APTC)	
State	Average APTC per Month (for all APTC enrollees)
National Average	\$291
Alabama	\$310
Alaska	\$750
Arizona	\$230
Arkansas	\$306
California	\$309
Colorado	\$318

Connecticut	\$357
Delaware	\$330
District of Columbia	\$183
Florida	\$305
Georgia	\$291
Hawaii	\$270
Idaho	\$265
Illinois	\$237
Indiana	\$259
Iowa	\$307
Kansas	\$247
Kentucky	\$258
Louisiana	\$362
Maine	\$342
Maryland	\$243
Massachusetts	\$190
Michigan	\$233
Minnesota	\$203
Mississippi	\$306
Missouri	\$315
Montana	\$306
Nebraska	\$296
Nevada	\$268
New Hampshire	\$261
New Jersey	\$322
New Mexico	\$212
New York	\$178
North Carolina	\$401
North Dakota	\$262
Ohio	\$250
Oklahoma	\$298
Oregon	\$253
Pennsylvania	\$248
Rhode Island	\$250
South Carolina	\$312
South Dakota	\$307
Tennessee	\$299
Texas	\$271
Utah	\$187

Vermont	\$300
Virginia	\$276
Washington	\$238
West Virginia	\$388
Wisconsin	\$332
Wyoming	\$459

March 2016: Total Effectuated Enrollment by Metal Level by State

There are four “metal levels” of coverage available through the Marketplace, plus catastrophic plans. Plans in each category can be expected to pay different amounts of the total costs of an average person’s care. This takes into account the plans’ deductibles, copayments, coinsurance, and out-of-pocket maximums. The actual percentage a consumer pays in total or per service will depend on the services used during the year.

- **Catastrophic:** The health plan pays less than 60% of the total average cost of care on average, with consumers paying the balance. These plans are only available to people who are under 30 years old at the beginning of the plan year, or those who have a hardship or affordability exemption.
- **Bronze:** The health plan pays about 60% and consumer pays about 40%, on average.
- **Silver:** The health plan pays about 70% and consumer pays about 30%, on average. Consumers eligible for CSRs can only receive them by enrolling in a silver plan. (Note, American Indians and Alaska Natives can receive CSRs through any metal-level plan.)
- **Gold:** The health plan pays about 80% and consumer pays about 20%, on average.
- **Platinum:** The health plan pays about 90% and consumer pays about 10%, on average.

Of the approximately 11.1 million consumers with effectuated enrollment in Marketplace plans at the end of March 2016, less than half a percent were enrolled in Catastrophic plans, 22% were enrolled in Bronze plans, 70% enrolled in Silver plans, 6% enrolled in Gold plans, and 2% enrolled in Platinum plans.

Table 3: March 31, 2016 Total Effectuated Enrollment Data by Metal Level by State

March 2016 Total Effectuated Enrollment by Metal Level		
State	Metal Level	Enrollees
Total	Total	11,081,330
Total	Bronze	2,427,537
Total	Catastrophic	67,807
Total	Gold	697,157
Total	Platinum	166,846
Total	Silver	7,721,983
Alabama	Bronze	11,966

Alabama	Catastrophic	1,579
Alabama	Gold	7,068
Alabama	Platinum	621
Alabama	Silver	144,300
Alaska	Bronze	8,476
Alaska	Catastrophic	82
Alaska	Gold	584
Alaska	Silver	8,853
Arizona	Bronze	39,297
Arizona	Catastrophic	3,345
Arizona	Gold	19,915
Arizona	Platinum	1,180
Arizona	Silver	115,708
Arkansas	Bronze	12,299
Arkansas	Catastrophic	348
Arkansas	Gold	6,046
Arkansas	Silver	44,664
California	Bronze	379,710
California	Catastrophic	288
California	Gold	71,548
California	Platinum	54,273
California	Silver	909,609
Colorado	Bronze	49,815
Colorado	Gold	7,790
Colorado	Platinum	947
Colorado	Silver	49,759
Connecticut	Bronze	22,981
Connecticut	Catastrophic	1,327
Connecticut	Gold	12,892
Connecticut	Platinum	1,449
Connecticut	Silver	64,268
Delaware	Bronze	5,503
Delaware	Catastrophic	94
Delaware	Gold	3,413
Delaware	Platinum	680
Delaware	Silver	15,689
District of Columbia	Bronze	4,798
District of Columbia	Catastrophic	890
District of Columbia	Gold	3,536

District of Columbia	Platinum	2,757
District of Columbia	Silver	5,685
Florida	Bronze	224,732
Florida	Catastrophic	7,166
Florida	Gold	59,095
Florida	Platinum	21,497
Florida	Silver	1,219,224
Georgia	Bronze	74,007
Georgia	Catastrophic	5,293
Georgia	Gold	26,081
Georgia	Silver	372,635
Hawaii	Bronze	2,036
Hawaii	Catastrophic	28
Hawaii	Gold	1,001
Hawaii	Platinum	830
Hawaii	Silver	9,418
Idaho	Bronze	21,573
Idaho	Catastrophic	772
Idaho	Gold	6,889
Idaho	Silver	65,036
Illinois	Bronze	97,365
Illinois	Catastrophic	1,313
Illinois	Gold	33,444
Illinois	Silver	203,121
Indiana	Bronze	57,689
Indiana	Catastrophic	685
Indiana	Gold	8,003
Indiana	Silver	102,507
Iowa	Bronze	13,626
Iowa	Catastrophic	73
Iowa	Gold	2,906
Iowa	Platinum	14
Iowa	Silver	32,330
Kansas	Bronze	18,766
Kansas	Gold	6,931
Kansas	Platinum	1,287
Kansas	Silver	62,582
Kentucky	Bronze	20,205
Kentucky	Gold	8,000

Kentucky	Platinum	42
Kentucky	Silver	46,393
Louisiana	Bronze	36,891
Louisiana	Catastrophic	898
Louisiana	Gold	10,185
Louisiana	Platinum	2,107
Louisiana	Silver	134,322
Maine	Bronze	16,796
Maine	Catastrophic	519
Maine	Gold	3,598
Maine	Silver	54,327
Maryland	Bronze	30,980
Maryland	Catastrophic	2,230
Maryland	Gold	10,754
Maryland	Platinum	1,074
Maryland	Silver	90,170
Massachusetts	Bronze	7,224
Massachusetts	Catastrophic	650
Massachusetts	Gold	9,741
Massachusetts	Platinum	5,716
Massachusetts	Silver	183,790
Michigan	Bronze	78,137
Michigan	Catastrophic	2,755
Michigan	Gold	18,482
Michigan	Platinum	2,617
Michigan	Silver	211,132
Minnesota	Bronze	36,136
Minnesota	Catastrophic	864
Minnesota	Gold	11,252
Minnesota	Silver	25,808
Mississippi	Bronze	9,022
Mississippi	Catastrophic	463
Mississippi	Gold	2,376
Mississippi	Platinum	525
Mississippi	Silver	65,361
Missouri	Bronze	65,626
Missouri	Catastrophic	910
Missouri	Gold	12,654
Missouri	Platinum	708

Missouri	Silver	172,146
Montana	Bronze	20,263
Montana	Catastrophic	458
Montana	Gold	2,665
Montana	Silver	28,372
Nebraska	Bronze	26,563
Nebraska	Catastrophic	935
Nebraska	Gold	3,202
Nebraska	Silver	49,513
Nevada	Bronze	17,253
Nevada	Catastrophic	449
Nevada	Gold	3,782
Nevada	Platinum	1,662
Nevada	Silver	56,730
New Hampshire	Bronze	16,807
New Hampshire	Catastrophic	797
New Hampshire	Gold	4,784
New Hampshire	Platinum	620
New Hampshire	Silver	26,106
New Jersey	Bronze	37,256
New Jersey	Catastrophic	767
New Jersey	Gold	20,084
New Jersey	Platinum	5,200
New Jersey	Silver	186,088
New Mexico	Bronze	9,864
New Mexico	Catastrophic	244
New Mexico	Gold	6,952
New Mexico	Platinum	288
New Mexico	Silver	30,149
New York	Bronze	55,734
New York	Catastrophic	1,816
New York	Gold	35,213
New York	Platinum	39,401
New York	Silver	91,850
North Carolina	Bronze	91,622
North Carolina	Catastrophic	5,958
North Carolina	Gold	17,964
North Carolina	Platinum	3,261
North Carolina	Silver	426,549

North Dakota	Bronze	5,063
North Dakota	Catastrophic	453
North Dakota	Gold	4,354
North Dakota	Silver	10,666
Ohio	Bronze	71,050
Ohio	Catastrophic	2,490
Ohio	Gold	15,734
Ohio	Platinum	514
Ohio	Silver	122,258
Oklahoma	Bronze	37,657
Oklahoma	Catastrophic	144
Oklahoma	Gold	5,943
Oklahoma	Silver	86,434
Oregon	Bronze	36,471
Oregon	Catastrophic	1,059
Oregon	Gold	13,166
Oregon	Silver	80,471
Pennsylvania	Bronze	59,995
Pennsylvania	Catastrophic	2,272
Pennsylvania	Gold	44,686
Pennsylvania	Platinum	6,107
Pennsylvania	Silver	299,287
Rhode Island	Bronze	6,696
Rhode Island	Gold	3,948
Rhode Island	Silver	24,939
South Carolina	Bronze	15,586
South Carolina	Catastrophic	1,148
South Carolina	Gold	7,704
South Carolina	Silver	180,408
South Dakota	Bronze	4,708
South Dakota	Catastrophic	268
South Dakota	Gold	1,040
South Dakota	Silver	18,562
Tennessee	Bronze	58,967
Tennessee	Catastrophic	1,565
Tennessee	Gold	7,470
Tennessee	Platinum	973
Tennessee	Silver	162,730
Texas	Bronze	283,356

Texas	Catastrophic	5,462
Texas	Gold	61,993
Texas	Platinum	4,016
Texas	Silver	737,823
Utah	Bronze	23,209
Utah	Catastrophic	445
Utah	Gold	17,355
Utah	Platinum	622
Utah	Silver	122,784
Vermont	Bronze	5,414
Vermont	Catastrophic	315
Vermont	Gold	2,594
Vermont	Platinum	2,702
Vermont	Silver	16,858
Virginia	Bronze	81,533
Virginia	Catastrophic	5,112
Virginia	Gold	24,402
Virginia	Platinum	1,452
Virginia	Silver	266,339
Washington	Bronze	54,015
Washington	Catastrophic	1,379
Washington	Gold	13,175
Washington	Silver	89,676
West Virginia	Bronze	6,294
West Virginia	Catastrophic	79
West Virginia	Gold	3,571
West Virginia	Silver	23,291
Wisconsin	Bronze	50,540
Wisconsin	Catastrophic	1,536
Wisconsin	Gold	10,425
Wisconsin	Platinum	1,704
Wisconsin	Silver	160,003
Wyoming	Bronze	5,965
Wyoming	Catastrophic	84
Wyoming	Gold	767
Wyoming	Silver	15,260

2016 Data Matching

In operating the Marketplace, we are committed to providing access to coverage and financial assistance to individuals and families who are eligible while maintaining strong program integrity protections. Throughout 2014, 2015, and into 2016, the Marketplace has worked to resolve consumers' data matching issues, including for those individuals whose citizenship, immigration status, or household income application information did not match information in our trusted data sources.

The Marketplace takes regular, monthly action for consumers with unresolved data matching issues who have not provided adequate documentation within 95 days for citizenship or immigration status data matching issues and within 90 days for household income inconsistencies. Consumers who do not submit sufficient documentation to resolve their annual household income data matching issue will have a recalculation of their APTC and/or CSRs based on available tax data. Individuals who have not provided the necessary documentation for their citizenship or immigration status will have their enrollment through the Marketplace terminated. Those individuals whose enrollment through the Marketplace was terminated because of citizenship or immigration status data matching issues are not included in effectuated enrollment totals.

During the time period from January 1, 2016 to March 31, 2016, enrollment in coverage through the Federally-facilitated Marketplace was terminated for about 17,000 consumers with unresolved citizenship or immigration status data matching issues. During the same time period, 73,000 households with unresolved annual household income data matching issues had their APTC and/or CSRs for 2016 coverage adjusted. Compared to the first quarter of last year, this represents an 85 percent decrease in the number of consumers whose coverage ended because of an unresolved citizenship or immigration data matching issue, and a 69 percent decrease in households with income data matching issues who had their advanced payment of the premium tax credit and/or their cost sharing reduction adjusted.

If consumers believe they have the appropriate documentation but their enrollment through the Marketplace was terminated based on a citizenship/immigration status data matching issue, they are able to submit their documentation to the Marketplace to resolve the data matching issue and regain enrollment through the Marketplace through a Special Enrollment Period.

Addendum Report: Special Enrollment Period Sign ups in 2015

In the Health Insurance Marketplace, most consumers select a plan during the annual Open Enrollment Period. Consumers who experience one of [six types of life events](#) can also select a plan during a special enrollment period. For states on the HealthCare.gov platform during 2015, 1.6 million individuals who did not select a plan during open enrollment made a plan selection through a special enrollment period (SEP).

The majority of these consumers (60 percent) received a special enrollment period for loss of minimum essential coverage. This means the consumer enrolled in Marketplace coverage after losing other health insurance, like coverage from their job. In addition, 18 percent of SEP plan selections were made by consumers who initially applied for coverage during open enrollment but needed to receive an eligibility determination from their state Medicaid agency before they could be determined eligible for Marketplace coverage and/or financial assistance. The tax season SEP for 2015 accounted for 9 percent of SEP plan selections. The tax SEP was not available for 2016.

Finally, small numbers of consumers enrolled for other reasons, including birth, adoption, marriage, a move, or other circumstances.

These figures include only consumers who did not have a plan selection during open enrollment; a consumer who enrolled during open enrollment and used an SEP to change plans is not reflected here.

Table 1: Distribution of SEP Reasons among 2015 Consumers with a Plan Selection Outside of the OE2 Baseline Population

SEP Reason	Count of Plan Selections	% of Plan Selections
Minimum Essential Coverage (MEC) loss	959,714	59.50%
Applicant attested to being denied Medicaid	286,266	17.70%
2015 Tax SEP	152,251	9.40%
Moved to a new service area	57,836	3.60%
Exceptional Circumstance	54,641	3.40%
Other SEPs	54,469	3.40%
Baby born in household	30,973	1.90%
Granted for marriage in household	14,692	0.90%
Granted for adoption in household	3,268	0.20%
Total	1,614,110	100.0%

###

Guidance for SBM No Cost Extensions in 2017

Today, the Centers for Medicare and Medicaid Services (CMS) released updated guidance for current 1311 grantees on the requirements for requesting a no cost extension for their remaining grant funds for up to one year.

The guidance provides information for current grantees under section 1311 of the Affordable Care Act (ACA) on the requirements for requesting a No Cost Extension (NCE). This information supplements the prior Centers for Medicare & Medicaid Services (CMS) guidance entitled, “FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities”, published in March 2014.

For more information, click here: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/No-Cost-Extension-Guidance-6-28-16-final.pdf>

###

Medicare and Medicaid Updates

First Release of the Overall Hospital Quality Star Rating on *Hospital Compare*

Overview

Today, we are updating the star ratings on the *Hospital Compare* website to help millions of patients and their families learn about the quality of hospitals, compare facilities in their area side-by-side, and ask important questions about care quality when visiting a hospital or other health care provider. Today's update comes after substantive discussions with hospitals and other stakeholders to review the Overall Hospital Quality Star Rating's methodology. To learn more about our outreach and education with stakeholders and hospitals, please visit:

<http://blog.cms.gov/2016/07/27/helping-consumers-make-care-choices-through-hospital-compare>

Background

The Overall Hospital Quality Star Rating is designed to help individuals, their family members, and caregivers compare hospitals in an easily understandable way. Over the past decade, the Centers for Medicare & Medicaid Services (CMS) has published information about the quality of care across the five different health care settings that most families encounter.^[1]

The new Overall Hospital Quality Star Rating summarizes data from existing quality measures publicly reported on *Hospital Compare* into a single star rating for each hospital, making it easier for consumers to compare hospitals and interpret complex quality information. This overall rating supplements the star ratings currently posted for hospitals on their [patient experience of care data](https://www.medicare.gov/HospitalCompare/Data/Patient-Experience-Domain.html) (<https://www.medicare.gov/HospitalCompare/Data/Patient-Experience-Domain.html>), based on data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. The patient experience of care hospital star ratings were first publicly reported in April 2015.

The methodology for the new Overall Hospital Quality Star Rating was developed with significant input from a Technical Expert Panel (TEP) and refined after public input. CMS will continue to analyze the star rating data and consider public feedback to make enhancements to the scoring methodology as needed. The star rating will be updated quarterly, and will incorporate new measures as they are publicly reported on the website as well as remove measures retired from the quality reporting programs.

We have received numerous letters from national patient and consumer advocacy groups supporting the release of these ratings because it improves the transparency and accessibility of hospital quality information. In addition,

^[1] CMS Compare websites include: [Nursing Home Compare](#); [Physician Compare](#); [Medicare Plan Finder](#); [Dialysis Compare](#); and [Home Health Compare](#).

researchers found that hospitals with more stars on the *Hospital Compare* website have tended to have lower death and readmission rates.^{[2], [3]}

Measures Selected for Inclusion in Overall Rating

The new Overall Hospital Quality Star Rating will include 64 of the more than 100 measures displayed on *Hospital Compare*. CMS collects the information on these measures through the [Hospital Inpatient Quality Reporting \(IQR\) Program](#) and [Hospital Outpatient Quality Reporting \(OQR\) Program](#).

Hospitals are only assessed on the measures for which they submit data. Some of the measures used to calculate the Overall Hospital Quality Star Rating are based only on data from Medicare beneficiaries and some are based on data from hospitals' general patient population, regardless of payer. For example, measures on deaths, readmissions, and use of medical imaging include data from Medicare beneficiaries only. The patient experience, safety, and timely and effective care measures include data from any adult patient treated at hospitals. Specialized and cutting edge care that certain hospitals provide, such as specialized cancer care, are not reflected in these quality ratings.

A complete list of measures included in this star rating is provided in the *Overall Hospital Quality Star Rating Methodology Report* available on [QualityNet](#).

Methodology for Calculating the Star Rating

The methodology for the new Overall Hospital Quality Star Rating was developed with significant input from a Technical Expert Panel (TEP) and refined after public input. The TEP, which included nominated individuals with various expertise, met three times. The first meeting established the inclusion criteria for measures to be included in the star rating, and the second and third meetings established the methodology to calculate the star rating.

We also hosted two opportunities for public input and hosted two National Provider Calls with over 4,000 participants. Hospitals had an opportunity to review their Overall Hospital Quality Star Rating, ask questions, and provide feedback during a "dry run" in July and August 2015.

CMS designed the methodology to be inclusive of as many hospitals and as many measures as possible. This approach prevents the methodology from limiting star rating calculations to certain types of hospitals based on characteristic or size. CMS will continue to re-evaluate and make any needed modifications to the methodology over time. We will also continue to work closely with hospitals and other stakeholders to enhance the Overall Hospital Quality Star Rating based on feedback and experience.

Today, we are taking a step forward in our commitment to transparency by releasing the Overall Hospital Quality Star Rating. We have been posting star ratings for different facilities for a decade and have found that publicly available data drives improvement, better reporting, and more open access to quality information for our Medicare beneficiaries. These star rating programs are part of the Administration's Open Data Initiative which aims to make government data freely available and useful while ensuring privacy, confidentiality, and security.

^[2] Wang DE, Tsugawa Y, Figueroa JF, Jha AK. Association Between the Centers for Medicare and Medicaid Services Hospital Star Rating and Patient Outcomes. *JAMA Intern Med*. 2016;176(6):848-850. doi:10.1001/jamainternmed.2016.0784.
<http://archinte.jamanetwork.com/article.aspx?articleid=2513630>

^[3] Trzeciak, S. Gaughan, J. Mazzarelli, A. Association Between Medicare Summary Star Ratings and Clinical Outcomes in US Hospitals. *Journal of Patient Experience*. 2016 vol. 3 no. 1 2374373516636681 doi: 10.1177/2374373516636681
<http://jpx.sagepub.com/content/3/1/2374373516636681.abstract>

For more information on the methodology, please see the *Overall Hospital Quality Star Rating Methodology Report* available on [QualityNet](#).

###

Medicaid & CHIP: May 2016 Monthly Applications, Eligibility Determinations and Enrollment Report

Today the Centers for Medicare & Medicaid Services (CMS) released a monthly report on state Medicaid and Children's Health Insurance Program (CHIP) data represents state Medicaid and CHIP agencies' eligibility activity for the calendar month of May 2016. This report measures eligibility and enrollment activity for the entire Medicaid and CHIP programs in all states, reflecting activity for all populations receiving comprehensive Medicaid and CHIP benefits in all states, including states that have not yet chosen to adopt the new low-income adult group established by the Affordable Care Act.

This data is submitted to CMS by states using a common set of indicators designed to provide information to support program management and policy-making related to application, eligibility, and enrollment processes. As with previous reports, this month's report focuses on those indicators that relate to the Medicaid and CHIP application and enrollment process.

Click here to view the report (PDF):

<https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/may-2016-enrollment-report.pdf>

For additional information and Excel Sheet click here:

<https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html>

###

CMS Finalizes Rule Giving Providers and Employers Improved Access to Information for Better Patient Care: MACRA provides expanded opportunity for the use of Medicare and private sector claims data to drive higher quality, lower cost care

The Centers for Medicare & Medicaid Services (CMS) today finalized new rules that will enrich the Qualified Entity Program by expanding access to analyses and data that will help providers, employers, and others make more informed decisions about care delivery and quality improvement. The new rules, as required by the Medicare Access and CHIP Reauthorization Act (MACRA), allow organizations approved as qualified entities to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers, and other groups who can use the data to support improved care. In addition, qualified entities may provide or sell claims data to providers and suppliers, such as doctors, nurses, and skilled nursing facilities among others. The rule also includes strict privacy and security requirements for all entities receiving patient identifiable and beneficiary de-identified analyses or data, as well as expanded annual reporting requirements. For example, if entities receive patient identifiable data or analyses, they must use protections that are at least as stringent as what is required of covered entities and their business associates for protected health information (PHI) under the HIPAA Privacy and Security Rules.

This initiative is part of a broader effort by the Obama Administration to use data to help create a health care system that delivers better care for patients, spends dollars more wisely, and results in healthier people.

“Increasing access to analyses and data that include Medicare data will make it easier for stakeholders throughout the healthcare system to make smarter and more informed healthcare decisions,” said CMS Chief Data Officer Niall Brennan.

The Qualified Entity Program was authorized by Section 10332 of the Affordable Care Act and allows organizations that meet certain qualifications to access patient-protected Medicare data to produce public reports. Qualified entities must combine the Medicare data with other claims data (e.g., private payer data) to produce quality reports that are representative of how providers and suppliers are performing across multiple payers, for example Medicare, Medicaid, or various commercial payers. Currently, 15 organizations have applied and received approval to be a qualified entity. Of these organizations, two have completed public reporting while the other 13 are preparing for public reporting. Additional information on the qualified entity program can be found at the Qualified Entity Certification Program website at <https://www.qemedicaredata.org/SitePages/home.aspx>.

Today’s rules seek to enhance the current qualified entity program to allow innovative use of Medicare data for non-public quality improvement and care delivery efforts while ensuring the privacy and security of beneficiary information. For example, qualified entities can conduct analyses on chronically ill or other resource-intensive populations to increase quality and drive-down costs in the healthcare system. The final rule contains few changes from the proposed rule. Future rulemaking is anticipated to expand the data available to qualified entities to include standardized extracts of Medicaid data. The final rule is on display at the Office of the Federal Register at <https://www.federalregister.gov/>

###

HHS Announces New Actions to Combat Opioid Epidemic

U.S. Health and Human Services (HHS) Secretary Sylvia M. Burwell yesterday announced several new actions the department is taking to combat the nation’s opioid epidemic.

The actions include expanding access to buprenorphine, a medication to treat opioid use disorder, a proposal to eliminate any potential financial incentive for doctors to prescribe opioids based on patient experience survey questions, and a requirement for Indian Health Service prescribers and pharmacists to check state Prescription Drug Monitoring Program (PDMP) databases before prescribing or dispensing opioids for pain. In addition, the department is launching more than a dozen new scientific studies on opioid misuse and pain treatment and soliciting feedback to improve and expand prescriber education and training programs. Read [more about the announcement](#).

###

Physician Fee Schedule: Proposed CY 2017 Changes

Medicare also expands the Diabetes Prevention Program

On July 7, CMS proposed changes to the Physician Fee Schedule to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. The rule also proposes policies to expand the Diabetes Prevention Program within Medicare starting January 1, 2018.

The annual Physician Fee Schedule updates payment policies, payment rates, and quality provisions for services provided in calendar year 2017. These services include, but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. In addition to physicians, the fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities. Additional policies proposed in the 2017 payment rule include:

- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning
- Care for patients with mobility-related impairments

For More Information:

- [Proposed Rule](#) (CMS-1654-P): Comments due no later than 5 pm on September 6, 2016
- [Fact Sheet](#)
- [Blog](#)
- [Diabetes Prevention Program](#)

See the full text of this excerpted [CMS press release](#) (issued July 7).

###

Hospital and ASC: Proposed OPPS Changes for CY 2017

On July 6, CMS proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers. These proposals are based on feedback from stakeholders, including beneficiary and patient advocates, as well as health care providers, including hospitals, ambulatory surgical centers and the physician community.

Proposed changes include:

- Addressing physicians' concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology
- Emphasizing health outcomes that matter to the patient

CMS estimates that the updates in the proposed rule would increase OPPS payments by 1.6 percent and ASC payments by 1.2 percent in 2017.

For More Information:

- [Proposed Rule](#) (CMS-1656-P): Comments due no later than 5 pm on September 6, 2016
- [Fact Sheet](#)

See the full text of this excerpted [CMS press release](#) (issued July 6).

###

Administrative Simplification Enforcement and Testing Tool (ASETT)

The Centers for Medicare & Medicaid Services takes seriously its role overseeing Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities' compliance with nationally-adopted transactions, code sets, unique identifiers, and operating rules. A key part of this enforcement is ensuring the public has an opportunity to submit complaints related to covered entities compliance with adopted standards and operating rules. This application is called the Administrative Simplification Enforcement and Testing Tool, or ASETT.

ASETT is a web- based application which enables individuals or organizations to file a complaint against a HIPAA covered entity (which includes health care providers, health plans, and clearinghouses) for potential non-compliance with the HIPAA adopted transactions, code sets, unique identifiers and operating rules.

For more information on the new and improved Administrative Simplification Enforcement and Testing Tool (ASETT) and how to file a complaint click here: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/FileaComplaint.html>

- ASETT Fact Sheet: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/Downloads/ASETTFactSheetWHClean2016June23.pdf>
- ASETT Quick Start Guide: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/Downloads/ASETTQuickStartGuidev3Final20160627.pdf>
- ASETT Frequently Asked Questions (FAQs) <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/Downloads/ASETTFAQsFinal20160627.pdf>

###

CMS' Open Payments Program Posts 2015 Financial Data: Health care industry manufacturers reported \$7.52 billion in payments and ownership and investment interests to physicians and teaching hospitals in 2015

The Centers for Medicare & Medicaid Services (CMS) published 2015 Open Payments data, along with newly submitted and updated payment records for the 2013 and 2014 reporting periods, at <https://openpaymentsdata.cms.gov/>. The Open Payments program (sometimes called the "Sunshine Act") requires that transfers of value by manufacturers of drugs, devices, biologicals, and medical supplies that are paid to physicians and teaching hospitals will be published on a public website.

For Open Payments program year 2015, health care industry manufacturers reported \$7.52 billion in payments and ownership and investment interests to physicians and teaching hospitals. This amount is comprised of 11.90 million total records attributable to 618,931 physicians and 1,116 teaching hospitals.

Payments in the three major reporting categories are:

- \$2.60 billion in general (i.e., non-research related) payments
- \$3.89 billion in research payments
- \$1.03 billion of ownership or investment interests held by physicians or their immediate family members

Over the course of the Open Payments program since 2014, we have published 28.22 million records, accounting for \$16.77 billion in payments and ownership and investment interests.

The Open Payments 2015 program year data set is the second full year of data available on the CMS Open Payments website. The availability of consecutive, full-year data allows the public the opportunity to explore trends in the health care industry manufacturers' payments to physicians and teaching hospitals for items and services such as food and beverage, travel, education, honoraria, and research. We are also able to analyze payments related to covered drugs, devices, biologicals, and supplies. For example, CMS has determined that for program year 2015, 2.26 percent (637,131 records) of all financial transactions between physicians and pharmaceutical companies was related to opioid medications.

"Transparency is empowering physicians to be purposeful about their financial relationships with companies, and there is a notable shift towards charitable contributions and away from other interactions such as honoraria and gifts," said Dr. Shantanu Agrawal, a CMS deputy administrator and director of the Center for Program Integrity.

The amount and distribution of payments and ownership and investment interest categories remained consistent between the 2014 and 2015 reporting periods.

For more information, please visit: <https://openpaymentsdata.cms.gov/>.

###

CMS Proposes Hospital Outpatient Prospective Payment System Changes to Better Support Physicians and Improve Patient Care

The Centers for Medicare and Medicaid Services (CMS) proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers. These proposals are based on feedback from stakeholders, including beneficiary and patient advocates, as well as health care providers, including hospitals, ambulatory surgical centers and the physician community.

"The items in this proposal are designed to improve care and value when Medicare beneficiaries receive care in an outpatient setting," said Andy Slavitt, Acting CMS Administrator. "Today's proposed updates better support physicians in providing beneficiaries with the right care at the right time."

Addressing Physicians' Concerns Regarding Pain Management

Today's proposed rule would address physicians' and other health care providers' concerns that patient survey questions about pain management in the Hospital Value-Based Purchasing program unduly influence prescribing practices. While there is no empirical evidence of this effect, we propose to remove the pain management dimension from the Hospital Value-Based Purchasing program to eliminate any potential financial pressure clinicians may feel to overprescribe pain medications. CMS continues to believe that pain control is an appropriate part of routine patient care that hospitals should manage and is an important concern for patients, their families, and their caregivers. Thus, CMS is also currently developing and field testing alternative questions related to provider communications and pain to include in the program in future years. We will solicit comment on this alternative in future rulemaking.

Focusing Payments on Patients Rather than Setting

In addition, CMS is proposing policies to implement section 603 of the Bipartisan Budget Act of 2015, which provides that certain items and services provided by certain hospital off-campus outpatient departments would no longer be paid under the OPPS. Currently, Medicare pays for the same services at a higher rate if those services are

provided in a hospital outpatient department, rather than a physician's office. This payment differential has encouraged hospitals to acquire physician offices in order to receive the higher rates. This acquisition trend and difference in payment has been highlighted as a long-standing issue of concern by Congress, MedPAC, and the Department of Health and Human Services Office of Inspector General. This difference in payment also increases costs for the Medicare program and raises the cost-sharing liability for beneficiaries.

Congress addressed this issue through the Bipartisan Budget Act of 2015, and CMS proposes implementation details in today's proposed rule. CMS believes these proposed policies will help to ensure that Medicare beneficiaries – and the Medicare program – do not pay more for care simply because of the setting in which that care was received. The CMS Office of the Actuary estimates that these changes should reduce OPSS spending by approximately \$500 million in 2017. CMS sought comment and feedback from stakeholders during the development of this proposed rule, and CMS encourages further feedback during this proposal's comment period.

Improving Patient Care through Technology

CMS is supporting physicians and other providers through today's rule by increasing flexibility for hospitals and critical access hospitals that participate in the Medicare electronic health records (EHR) Incentive Program. Earlier this year, CMS conducted a review of the Medicare EHR Incentive Program for clinicians as part of our implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), with the aim of reconsidering the program so we move closer to achieving the full potential health information technology (IT) offers. Based on that review, CMS streamlined EHR reporting requirements under [the proposed rule to implement certain provisions of MACRA](#) to increase flexibility and support improved patient outcomes.

Today, we propose taking a similar step for hospitals and critical access hospitals participating in the Medicare EHR Incentive Program. These changes include a proposal for clinicians, hospitals, and critical access hospitals to use a 90-day EHR reporting period in 2016 – down from a full calendar year for returning participants. This increases flexibility and lowers the reporting burden for hospital providers.

Emphasizing Health Outcomes that Matter to the Patient

Finally, CMS proposes to add new quality measures to the Hospital Outpatient Quality Reporting Program and the Ambulatory Surgical Center Quality Reporting Program that are focused on improving patient outcomes and experience of care. Other changes in the proposed rule would enhance the outcome requirements for organ transplant programs, so that the programs may help more beneficiaries accept more grafts, while maintaining compliance with Medicare standards for patient and graft survival.

CMS estimates that the updates in the proposed rule would increase OPSS payments by 1.6 percent and ASC payments by 1.2 percent in 2017.

To learn more about the proposed rule, please visit: <https://www.federalregister.gov/public-inspection>. CMS looks forward to feedback on the proposal and will accept comments until September 6, 2016. Comments may be submitted electronically through our e-Regulation website at: <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html>.

A fact sheet on this proposed rule is available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-06.html>.

###

Bundled Payment for Care Improvement (BPCI) Downside Risk Waiver Notification

The Centers for Medicare & Medicaid Services (CMS) sent notifications to relevant stakeholders of a decision to waive downside risk calculations for physician group practice (PGP) episode initiators participating in Models 2 and 3 of the Bundled Payments for Care Improvement (BPCI) initiative as well as for impacted episodes for indirectly impacted Model 2 and 3 Awardees for all of 2015.

CMS will continue to analyze the situation and is considering additional short term and long term solutions for the provider reassignment and episode attribution issues. CMS will keep Awardees and external stakeholders apprised of the situation and the timeline.

PGP Reassignment Corrections Timeline Overview

Late Spring 2016 – Early Fall 2016	Processing time by the Medicare Administrative Contractors (MACs).
Fall 2016	CMS review of the results and correction of PGP Reassignment Lists.
October 2016	Q1 2016 Reconciliation Results released as per normal schedule.
Late Fall 2016	Corrected PGP Reassignment Lists issued by CMS. CMS offers an amendment to the BPCI Model Agreement to impacted Awardees that would eliminate downside risk for a certain time period for certain Episodes of Care.
January 2017	Distribution of Q2 2016 Reconciliation Reports and true-ups for Q1, Q2, Q3, and Q4 of 2015, as well as Q1 2016 reflecting episodes triggered based on new PGP Reassignment Lists.

The BPCI team will contact impacted Awardees and Awardee Conveners prior to the January 2017 reconciliation.

###

Medicare Electronic Health Records (EHR) Incentive Program Fiscal Year (FY) 2015 reduction in reimbursement for reasonable costs for critical access hospitals

The Centers for Medicare & Medicaid Services (CMS) issued letters to critical access hospitals (CAHs) that are subject to the 2015 Medicare Electronic Health Record (EHR) payment adjustment.

As part of The American Recovery and Reinvestment Act (ARRA), Congress required a reduction in the payment of reasonable costs beginning in FY 2015 for critical access hospitals that are not meaningful users under the Medicare EHR Incentive Program. This reduction applies to cost reporting periods beginning with FY 2015 for critical access

hospitals that did not successfully demonstrate meaningful use of Certified EHR Technology for an applicable EHR reporting period.

A CAH that did not successfully demonstrate meaningful use for the 2015 EHR reporting period (a minimum of 90 continuous days from October 1, 2014 through December 31, 2015) will be subject to a reduction in the payment of reasonable costs for the FY 2015 cost reporting period. In subsequent years, the EHR reporting period is the full calendar year that starts during the fiscal year. The payment adjustment applies to the Medicare reimbursement to the CAH for inpatient services during cost reporting periods starting in the fiscal year in which the CAH failed to demonstrate meaningful use.

Critical Access Hospitals (CAHs) Reconsideration Form

The deadline for CAHs to submit Reconsideration Forms for the 2015 payment adjustment, based on the FY 2015 EHR reporting period is November 30th, 2016. No applications will be accepted after the deadline. For inquiries about the Reconsideration Form, please email pareconsideration@provider-resources.com.

For additional information on Payment Adjustment and Hardship click here:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

Payment Adjustment Fact sheet (PDF) click here:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExceptTipsheetforCAH.pdf

###

CMS Proposes Hospital Outpatient Prospective Payment System Changes to Better Support Physicians and Improve Patient Care

Today, the Centers for Medicare and Medicaid Services (CMS) proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers. These proposals are based on feedback from stakeholders, including beneficiary and patient advocates, as well as health care providers, including hospitals, ambulatory surgical centers and the physician community.

“The items in this proposal are designed to improve care and value when Medicare beneficiaries receive care in an outpatient setting,” said Andy Slavitt, Acting CMS Administrator. “Today’s proposed updates better support physicians in providing beneficiaries with the right care at the right time.”

Addressing Physicians’ Concerns Regarding Pain Management

Today’s proposed rule would address physicians’ and other health care providers’ concerns that patient survey questions about pain management in the Hospital Value-Based Purchasing program unduly influence prescribing practices. While there is no empirical evidence of this effect, we propose to remove the pain management

dimension from the Hospital Value-Based Purchasing program to eliminate any potential financial pressure clinicians may feel to overprescribe pain medications. CMS continues to believe that pain control is an appropriate part of routine patient care that hospitals should manage and is an important concern for patients, their families, and their caregivers. Thus, CMS is also currently developing and field testing alternative questions related to provider communications and pain to include in the program in future years. We will solicit comment on this alternative in future rulemaking.

Focusing Payments on Patients Rather than Setting

In addition, CMS is proposing policies to implement section 603 of the Bipartisan Budget Act of 2015, which provides that certain items and services provided by certain hospital off-campus outpatient departments would no longer be paid under the OPSS. Currently, Medicare pays for the same services at a higher rate if those services are provided in a hospital outpatient department, rather than a physician's office. This payment differential has encouraged hospitals to acquire physician offices in order to receive the higher rates. This acquisition trend and difference in payment has been highlighted as a long-standing issue of concern by Congress, MedPAC, and the Department of Health and Human Services Office of Inspector General. This difference in payment also increases costs for the Medicare program and raises the cost-sharing liability for beneficiaries.

Congress addressed this issue through the Bipartisan Budget Act of 2015, and CMS proposes implementation details in today's proposed rule. CMS believes these proposed policies will help to ensure that Medicare beneficiaries – and the Medicare program – do not pay more for care simply because of the setting in which that care was received. The CMS Office of the Actuary estimates that these changes should reduce OPSS spending by approximately \$500 million in 2017. CMS sought comment and feedback from stakeholders during the development of this proposed rule, and CMS encourages further feedback during this proposal's comment period.

Improving Patient Care through Technology

CMS is supporting physicians and other providers through today's rule by increasing flexibility for hospitals and critical access hospitals that participate in the Medicare electronic health records (EHR) Incentive Program. Earlier this year, CMS conducted a review of the Medicare EHR Incentive Program for clinicians as part of our implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), with the aim of reconsidering the program so we move closer to achieving the full potential health information technology (IT) offers. Based on that review, CMS streamlined EHR reporting requirements under [the proposed rule to implement certain provisions of MACRA](#) to increase flexibility and support improved patient outcomes.

Today, we propose taking a similar step for hospitals and critical access hospitals participating in the Medicare EHR Incentive Program. These changes include a proposal for clinicians, hospitals, and critical access hospitals to use a 90-day EHR reporting period in 2016 – down from a full calendar year for returning participants. This increases flexibility and lowers the reporting burden for hospital providers.

Emphasizing Health Outcomes that Matter to the Patient

Finally, CMS proposes to add new quality measures to the Hospital Outpatient Quality Reporting Program and the Ambulatory Surgical Center Quality Reporting Program that are focused on improving patient outcomes and experience of care. Other changes in the proposed rule would enhance the outcome requirements for organ transplant programs, so that the programs may help more beneficiaries accept more grafts, while maintaining compliance with Medicare standards for patient and graft survival.

CMS estimates that the updates in the proposed rule would increase OPPI payments by 1.6 percent and ASC payments by 1.2 percent in 2017.

To learn more about the proposed rule, please visit: <https://www.federalregister.gov/public-inspection>. CMS looks forward to feedback on the proposal and will accept comments until September 6, 2016. Comments may be submitted electronically through our e-Regulation website at: <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html>.

A fact sheet on this proposed rule is available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-06.html>.

###

HRSA Announced More Than \$36 Million In Funding For 50 Health Center Controlled Networks

HRSA announced more than \$36 million in funding for 50 Health Center Controlled Networks (HCCNs) in 41 states and Puerto Rico. These awards will increase health information technology support for more than 1,020 participating health center organizations in all 50 states and Puerto Rico.

“Health Center Controlled Networks are a key tool in providing quality primary care to medically underserved communities,” said Secretary Burwell. “By using these networks, individual health centers can work together to share resources, leverage buying power, and improve access to health information technology, leading to a better care experience for vulnerable populations.”

To find the **press release**, visit: www.hhs.gov/about/news/2016/07/21/hhs-awards-more-than-36-million-for-health-center-adoption-of-health-information-technology.html

Please help us to amplify these awards on social media using the below **sample tweet**:

\$36M #HRSA Grants for #HealthCenter Controlled Networks to improve #HealthIT and deliver #bettercare.

###

HRSA Announced More Than \$149 Million In New Awards Through 12 Workforce Programs

HRSA announced more than \$149 million in new awards through 12 workforce programs to prepare the next generation of skilled, diverse primary care providers to serve communities in need across the country.

To read the **press release** and learn more, visit: <http://www.hhs.gov/about/news/2016/07/20/hrsa-awards-more-149-million-grow-nation-s-primary-care-workforce-and-expand-health-professions.html>

Please help us to amplify information on these awards on social media with the below **sample tweets**:

- \$149M in #HRSA Grants to help educate and train the next generation of #healthcare providers serving our communities. [LINK]
- [@HRSAgov](#) awards \$149M through 12 workforce programs to educate and train more #healthcare workers. [LINK]
- \$149M in [@HRSAgov](#) awards supports our work to deliver #bettercare to America's underserved communities. [LINK]
- \$149M ✓ 12 workforce programs ✓ training America's future #primarycare providers ✓ helping us deliver #bettercare ✓
- \$149M to strengthen the #primarycare workforce and support our work to deliver #bettercare.

###

Medicare FFS Jurisdiction Specific Improper Payment FYs 2014 - 2015 Data Release

CMS will post the Fiscal Year (FY) 2014 and 2015 improper payment rate information for the Medicare Fee-For-Service (FFS) program for A/B, Home Health/Hospice, and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) jurisdictions. These jurisdictions were assigned during the 2014 and 2015 Medicare FFS improper payment reporting periods (i.e., July 1, 2012 – June 30, 2013, and July 1, 2013 – June 30, 2014, respectively).

After the release of the HHS Agency Financial Report in November 2015, CMS announced in a blog its efforts to explore additional improper payment data releases in multiple sectors. This information will be available on the Comprehensive Error Rate Testing (CERT) page on the CMS website.

For more information, visit: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/MedicareFFSJurisdictionErrorRateContributionData.html>

###

Improved Access to Medicare Knowledge, Resources & Training

Our [Medicare Learning Network](#) (MLN) website is updated to improve your access to education resources and make finding what you need easier. View the full edition as a: [PDF](#) | [Webpage](#)

Data Brief: Evaluation of National Distributions of Overall Hospital Quality Star Ratings

[Hospital Compare](#) is a consumer-oriented website that provides information on how well hospitals provide care to their patients. This information can help consumers make informed decisions about their health care. The Centers for Medicare & Medicaid Services (CMS) has been posting quarterly hospital quality star ratings based on patients' experience of care on the *Hospital Compare* website since April 16, 2015.

To continue our efforts to make quality of care information more readily available, we developed an Overall Hospital Quality Star Rating (Star Rating) that reflects comprehensive quality information about the care provided at our nation's hospitals. We have previously stated our intention to begin posting this overall star rating on *Hospital Compare* in 2016, which we expect to begin shortly. The Star Rating, which was developed through a public and transparent process, takes 62 existing quality measures already reported on the *Hospital Compare* website and summarizes them into a unified rating of one to five stars. The rating includes quality measures for the routine care an individual receives when being treated for heart attacks and pneumonia to quality measures that focus on hospital-acquired infections, such as catheter-associated urinary tract infections. Key measures included in the Star Rating ask questions such as:

- How often do patients get an infection after surgery?
- How long on average do patients have to wait in the Emergency Department before seeing a provider?
- How often do patients develop complications after hip replacement surgery?
- How likely are patients to get readmitted to the hospital after a heart attack?
- Will patients receive multiple CT scans or MRI's?

CMS intends to post the Overall Hospital Star Ratings for individual hospitals shortly. Today, CMS is publishing some data showing the national distribution of Overall Hospital Star Ratings based on hospital characteristics. For each hospital characteristic, such as teaching status or safety net status, CMS evaluated the distribution of hospitals across the five star categories (1, 2, 3, 4, and 5 stars).

This analysis furthers CMS' commitment to transparency in the development and reporting of the Overall Hospital Star Rating. We hope that by releasing our analysis of the impact of the overall star rating on different types of hospitals, we are able to clarify our ratings and address any questions or concerns about the data from stakeholders.

Method and Data Source

CMS examined the relationship between each hospital characteristic and the national distribution of the Star Rating. For each hospital characteristic, CMS compared the number of hospitals, the mean Star Rating, and the range (or the minimum and maximum Star Ratings). CMS evaluated the distribution of hospitals across the five star categories within each hospital characteristic. CMS also examined the distribution of hospital performance at the group level for each hospital characteristic using the hospitals' performance categories (Above, Same as, Below the National Average) for each of the seven groups.^[1]

CMS utilized hospital data from the July 2016 star ratings input file and defined the hospital characteristics based on the 2013 American Hospital Association (AHA) annual survey of hospital characteristics and the 2016 CMS IMPACT file, which is used for determining if a hospital is eligible to be a disproportionate share hospital.

Overall Star Rating Results based on Hospital Characteristics

CMS’s analysis shows that all types of hospitals have both high performing and low performing hospitals. In other words, hospitals of all types are capable of performing well on star ratings and also have opportunities for improvement.

Table 1. National Distribution of Overall Star Ratings

Overall Star Rating	Number of Hospitals (N=4,599, %)
5 Stars ()	102 (2.2%)
4 Stars ()	934 (20.3%)
3 Stars ()	1,770 (38.5%)
2 Stars ()	723 (15.7%)
1 Star ()	133 (2.9%)
N/A ²¹	937 (20.4%)

Overall Star Rating Results based on Bed Size

Hospitals of varying bed size – classified as 1-99, 100-199, and 200 or more beds – had similar average Star Ratings. Each bed size classification included hospitals with a Star Rating ranging from 1 to 5 stars.

Table 2. Results of Overall Star Rating Bed Size Analysis (AHA Survey data)

Bed Size	Mean (Std)						N/A
1-99 beds (N=2,244)	3.29 (0.69)	6 (0.3%)	125 (5.6%)	787 (35.1%)	454 (20.2%)	51 (2.3%)	821 (36.6%)
100-199 beds (N=946)	2.96 (0.81)	23 (2.4%)	222 (23.5%)	432 (45.7%)	194 (20.5%)	19 (2.0%)	56 (5.9%)
200 or more beds (N=1,329)	2.81 (0.93)	104 (7.8%)	370 (27.8%)	522 (39.3%)	277 (20.8%)	27 (2.0%)	29 (2.2%)

Overall Star Rating Results based on Teaching Status

The average Star Rating for teaching hospitals (mean = 2.87) was similar to but slightly lower than that for non-teaching hospitals (mean = 3.11). Both teaching and non-teaching status hospitals had high-performing and low-performing hospitals on the Star Ratings, ranging from 1 to 5 stars.

Table 3. Results of Overall Star Rating Teaching Status Analysis (AHA Survey data)

Teaching Status	Mean (Std)						N/A
Teaching (N= 1,209)	2.87 (0.92)	80 (6.6%)	280 (23.2%)	466 (38.5%)	252 (20.8%)	25 (2.1%)	106 (8.8%)
Non-Teaching (N= 3,310)	3.11 (0.79)	53 (1.6%)	437 (13.2%)	1,275 (38.5%)	673 (20.3%)	72 (2.2%)	800 (24.2%)

Overall Star Rating Results based on Safety Net Status

Applying a previously accepted definition of hospital safety net status,³¹ CMS found that safety net hospitals was similar to but slightly lower average Star Rating (mean = 2.88) than non-safety net hospitals (mean = 3.09). Both safety net and non-safety-net hospitals had high-performing and low-performing hospitals on the Star Ratings, ranging from 1 to 5 stars.

Table 4. Results of Overall Star Rating Safety Net Status Analysis

Safety Net Status	Mean (Std)	□	□□	□□□	□□□□	□□□□□	N/A
Safety Net (N=1,332)	2.88 (0.83)	50 (3.6%)	200 (15.0%)	426 (32.0%)	183 (13.7%)	7 (0.5%)	466 (35.0%)
Non-Safety Net (N=3,187)	3.09 (0.84)	83 (2.6%)	517 (16.2%)	1,315 (41.3%)	742 (23.3%)	90 (2.8%)	440 (13.8%)

Overall Star Rating Results based on Disproportionate Share Hospital (DSH) Payment Eligibility

CMS found a lower average Star Rating among DSH payment-eligible hospitals (mean = 2.92) in comparison to non-DSH payment-eligible hospitals (mean = 3.47). Both DSH payment-eligible and non-DSH payment-eligible hospitals groups had hospitals with Star Ratings ranging from 1 to 5 stars.

Table 5. Results of Overall Star Rating DSH Payment Eligibility Analysis (2016 IMPACT File)

DSH Payment Eligibility	Mean (Std)	□	□□	□□□	□□□□	□□□□□	N/A
DSH Payment Eligible (N=2,707)	2.92 (0.84)	129 (4.8%)	653 (23.5%)	1,235 (45.6%)	557 (20.6%)	41 (1.5%)	110 (4.1%)
Non-DSH Payment Eligible (N=623)	3.47 (0.87)	4 (0.6%)	57 (9.2%)	204 (32.7%)	182 (29.2%)	60 (9.6%)	116 (18.6%)

Overall Star Rating Results based on Critical Access Hospital (CAH) Status

CMS found a higher average Star Rating among CAHs (mean = 3.31) in comparison to the average Star Rating among non-CAHs (mean = 2.99). The range of among CAHs was more narrowly distributed, from 2 to 4 stars, while the range of Star Ratings among non-CAHs was more broadly distributed, from 1 to 5 stars.

Table 6. Results of Overall Star Rating CAH Designation Analysis (AHA Survey data)

CAH Designation	Mean (Std)	□	□□	□□□	□□□□	□□□□□	N/A
CAH (N=1,211)	3.31 (0.56)	0 (0%)	27 (2.2%)	321 (26.5%)	191 (15.8%)	1 (0.1%)	671 (55.4%)
Non-CAH (N=3,308)	2.99 (0.87)	133 (4.0%)	690 (20.9%)	1,420 (42.9%)	734 (22.2%)	96 (2.9%)	235 (7.1%)

###

Medicare announces participants for a new initiative to prevent heart attacks and strokes

The Centers for Medicare & Medicaid Services (CMS) announced 516 awardees in 47 states, Puerto Rico, and the District of Columbia to help reduce the risks for heart attacks and strokes among millions of Medicare fee-for-service beneficiaries. The health care practitioners participating in the Million Hearts® Cardiovascular Disease Risk

Reduction Model will work to decrease cardiovascular disease risk by assessing an individual patient's risk for heart attack or stroke and applying prevention interventions.

"Our health care system historically often emphasized acute care over preventive care," said Dr. Patrick Conway, CMS Acting Principal Deputy Administrator and Chief Medical Officer. "This initiative will enhance patient-centered care and give practitioners the resources to invest the time and in staff to address and manage patients who are at high risk for heart attacks and strokes."

According to the Centers for Disease Control and Prevention (CDC), heart disease is the leading cause of death and a major contributor to disability in the United States. One in three deaths are caused by heart attacks and strokes, resulting in over \$300 billion of health care costs each year. Currently, health care practitioners are paid to screen for blood pressure, cholesterol, or other risk factors individually. In testing a new approach, practitioners participating in the Million Hearts® Cardiovascular Disease Risk Reduction Model's intervention group will use a data-driven, widely accepted predictive modeling approach to generate personalized risk scores and develop specific plans in partnership with patients to reduce the risk of having a heart attack or stroke.

Overall, nearly 20,000 health care practitioners and over 3.3 million Medicare fee-for-service beneficiaries will participate in the five-year model. Health care practitioners in the intervention group will work with beneficiaries individually to identify the best approach or approaches to reducing their risk of having a heart attack or stroke – for example, smoking cessation interventions, blood pressure management, or cholesterol-lowering drugs or aspirin – and will explain the benefits of each approach. Each beneficiary will receive a personalized risk modification plan that will target their specific risk factors. Organizations in the intervention group will be paid for reducing the absolute risk for heart disease or stroke among their high-risk beneficiaries.

The Affordable Care Act, through the creation of the CMS Innovation Center, allows for the testing of innovative payment and service delivery models, such as the Million Hearts® Cardiovascular Disease Risk Reduction Model, to move our health care system toward one that spends dollars more wisely, delivers better care, and makes individuals and communities healthier. Today's announcement is part of the Administration's broader strategy to improve the health care system by paying practitioners for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality. In March 2016, the Administration announced it reached its [goal](#), nearly one year ahead of schedule, of tying 30 percent of Medicare payments to alternative payment models that reward the quality of care over the quantity of services provided to beneficiaries.

This model is part of Million Hearts®, a broad national initiative co-led by CMS and CDC to prevent one million heart attacks and strokes by 2017. Million Hearts® brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke. For more information on the Million Hearts® initiative, please visit: <https://millionhearts.hhs.gov>.

For additional information about the Million Hearts® Cardiovascular Risk Reduction Model, including a fact sheet and a list of participants, please visit: <https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/>.

###

Contraceptive Services RFI (CMS 9931-NC)

Today, the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury issued a request for information (RFI) to determine whether modifications to the existing accommodation procedure could resolve religious objections, while still ensuring that affected women seamlessly receive full and equal health coverage, including contraceptive coverage. The Departments are issuing this RFI to solicit feedback from all interested stakeholders in light of the Supreme Court decision in *Zubik v. Burwell*.

For more information on today's Contraceptive Services RFI at the *Federal Register* click here:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-17242.pdf>

And on 07/22/2016 will be available online at <http://federalregister.gov/a/2016-17242>

###

LTCH Quality Reporting Program: Non-Compliance Letters

Long-Term Care Hospitals (LTCHs) have been notified if they were determined to be non-compliant with LTCH Quality Reporting Program (QRP) requirements for CY 2015, which will affect their FY 2017 APU. Non-compliance notifications were placed into provider's CASPER folders in QIES on July 20, 2016. Providers that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 19, 2016. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the [LTCH Quality Reporting Reconsideration and Exception & Extension](#) webpage. This webpage also lists contact information for those provider that have questions about their reports.

###

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) NHSN data

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) NHSN data for Q1 of calendar year (CY) 2016 and LTCH CARE data for Q1 of CY 2016, including NQF #0680 – Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay), must be submitted on August 15, 2016. For additional information, including a list of quality measure data that is due, visit the [LTCH Quality Reporting Data Submissions Deadlines](#) webpage.

###

IRF Quality Reporting Program: Non-Compliance Letters

CMS has provided notifications to facilities that were determined to be out of compliance with Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) requirements for CY 2015, which will affect their FY 2017 APU. Non-compliance notifications were placed into facilities CASPER folders in QIES on July 20, 2016. Facilities that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 19, 2016. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the [IRF Quality Reporting Reconsideration and Exception & Extension](#) webpage. This webpage also lists contact information for those provider that have questions about their reports.

###

Medicare projects relatively stable average prescription drug premiums in 2017

Medicare announced that the average basic premium for a Medicare Part D prescription drug plan in 2017 is projected to remain relatively stable at an estimated \$34 per month. This represents an increase of approximately \$1.50 over the actual average premium of \$32.56 in 2016.

“Stable Medicare prescription drug plan premiums help seniors and people with disabilities afford their prescription drugs,” said Andy Slavitt, Acting Administrator of the Centers for Medicare & Medicaid Services (CMS). “However, I remain increasingly concerned about the rising cost of drugs, especially high-cost specialty drugs, and the impact of these costs on the Medicare program.”

The stability in average basic Medicare Part D premiums for enrollees comes despite the fact that Part D costs continue to increase faster than other parts of Medicare, largely driven by high-cost specialty drugs and their effect on spending in the catastrophic benefit phase. Although private prescription drug plans receive capitated payments for portions of the Part D benefit, Medicare is directly responsible for 80 percent of the cost of drugs purchased by beneficiaries while in the catastrophic benefit phase.

As the recent 2016 Medicare Trustees [report](#) noted, growth in the costs of prescription drugs paid by Medicare continue to exceed growth in other Medicare costs and overall health expenditures. Medicare Part D expenditures per enrollee are estimated to increase by an average of 5.8 percent annually through 2025, higher than the combined per-enrollee growth rate for Medicare Parts A and B (4.0 percent). The report found that these costs are trending higher than previously predicted, particularly for specialty drugs. In addition, a March 2016 Department of Health and Human Services [report](#) provided a detailed analysis of high-cost prescription drug spending trends.

Today’s projection for the average premium for 2017 is based on bids submitted by drug and health plans for basic drug coverage for the 2017 benefit year and calculated by the independent CMS Office of the Actuary.

Seniors and people with disabilities are continuing to see savings on out of pocket drug costs as the Affordable Care Act closes the Medicare Part D “donut hole” over time. Since the enactment of the Affordable Care Act, [more than 10.7 million](#) seniors and people with disabilities have received discounts of over \$20.8 billion on prescription drugs, an average of \$1,945 per beneficiary.

The upcoming annual Medicare open enrollment period begins on October 15, 2016, and ends on December 7, 2016. During this time, people with Medicare can choose health and drug plans for 2017 by comparing their current coverage and plan quality ratings to other plan offerings, or choose to remain in Original Medicare. CMS anticipates releasing the premiums and costs for Medicare health and drug plans for the 2017 calendar year in mid-September.

To view the Part D Base Beneficiary Premium, the Part D National Average Monthly Bid Amount, the Part D Regional Low-Income Premium Subsidy Amounts, the De Minimis Amount, the Part D Income-Related Monthly Adjustment Amounts, the 2017 Medicare Advantage Employer Group Waiver Plan Regional Payment Rates, and the Medicare Advantage Regional Benchmarks, go to: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html>, and select “2017.”

To learn more about the Medicare Part D prescription drug benefit, go to: <http://www.medicare.gov/part-d/>.

###

Upcoming Webinars and Events

Monthly Partner Update Webinar

August 2, 2016 2:30 – 3:30 pm ET

This webinar will feature presentations on:

- Pre-claim Review Demo for Home Health Services
- Medicare Summary Notice (MSN) Production in Audio & Braille

Registration is Required to Attend

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

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

###

CMS Low Income Health Access Open Door Forum

Date: Wednesday August 3, 2016 2:00-3:00 PM (EST)

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

Conference Leaders: Rita Vandivort-Warren & Jill Darling

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

Opening Remarks

Acting Chair – Rita Vandivort-Warren, HRSA, Office of Policy Analysis

Moderator – Jill Darling, CMS Office of Communications

Announcements & Updates

- Medicare Managed Care Regulations Announcement
- Proposed Changes to Chronic Care Management (CCM) and Transitional Care Management (TCM) Requirements
- Billing for Nursing Visits in Home Health Shortage Areas by an RHC or FQHC
- Proposed 2017 FQHC Market Basket

****DATE IS SUBJECT TO CHANGE****

Next ODF: November 30, 2016

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 Forum Participation Instructions:

This call will be Conference Call Only.

1. To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 42123169

Persons participating by phone are not required 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: 42123169

Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID, beginning 2 hours after the call has ended. The recording expires after 2 business days.

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

###

2016 Health Insurance Marketplace Training Calendar for CMS Partners

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

###

Is Your RHC Compliance Ready?

This webinar will be focused on RHC compliance and further on staying in compliance. Requirements will be discussed as well as practical methods to stay in compliance throughout the year.

Session goals:

- Decrease the stress and anxiety related to survey and certification
- Provide ideas on how to create and organize an ongoing process for survey readiness
- Learn the common deficiencies found by one Accreditation organization (AO)

Ongoing Rural Health Clinic Survey Readiness

Date: Wednesday, August 3, 2016 **Time:** 2:00 - 3:00 PM Central Time

Cost: Free

Target Audience: CEO, CFO, Clinic Managers, Nurse Practitioners, Physician Assistants, Medical Director, Nurses, Practice Managers

Presenters

Kate Hill, RN is a graduate of Albert Einstein Medical Center School of Nursing in Philadelphia, PA. As an Army Nurse, Kate served in Viet Nam (27th Surgical Hospital in Chu Lai) reaching the rank of 1st Lieutenant where she was awarded the Bronze Star for meritorious service. During the 1970's, Kate worked with orthopedic patients in several capacities including Head Nurse of Orthopedics at in Newark, NJ. Nearly 3-decades with Biomet followed in various capacities. In 2011 Kate operated Hill Medical a Pennsylvania-based negative pressure wound therapy DME firm. Kate joined The Compliance Team in early 2012 to direct TCT's rural health accreditation program and has fallen in love with Rural. As VP of Clinical Services she spearheaded the Rural Health Clinic Accreditation program combining her clinical expertise, business acumen and passion for patients getting the best care possible.

Marty Bennett is a 1992 graduate of Purdue University's School of Nursing. Specializing in ER and Adult Critical Care, she left direct patient care in 2002. In late 2006, her passion for expanding healthcare access to the underserved in her Southern Louisiana community led to her employment at Riverside Family Medicine. In this role she, participated in clinic start-up and RHC credentialing/licensure. In the course of her rural career, she transitioned from Office Mgr. to CFO. Marty's current role focuses on upper level finance, strategic planning, understanding the impact of legislative reform on rural medicine, and advocacy for Rural and NP led clinics.

[REGISTER TODAY](#)

Is Telemedicine Your Solution to Night Shift Coverage?

The webinar will focus on the benefits of telemedicine as a solution to night shift coverage. Members who attend will learn how telehospitalists can provide a cost-effective alternative to current nighttime staffing models through telenoaturnist care, telecross-coverage, and Eagle Surge Protection.

Following a brief introduction of telemedicine and its basic components, the webinar will focus on telemedicine's applications to nighttime staffing challenges, including:

- Telenoaturnist Care from remote physicians and on-site night charge nurses
- Telecross-Coverage between nighttime rounding and ED admissions during surges ("Eagle Surge Protection")
- Collaborative care between remote physicians and NP/PAs.

Attendees will learn how telenoaturnists and other telemedicine solutions can ease the night shift burdens faced by rural and larger hospitals, with benefits including customer satisfaction, quick physician access, cost savings, burnout reduction, and growth potential for nighttime admissions.

Telemedicine Night Shift Solutions: Why They Work for Hospitals and Physicians

Date: Thursday, August 4

Time: 2:00 - 3:00 PM Central Time

Cost: Free

Target Audience: Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Hospitalists, Physicians, Other Clinicians, Emergency Room Director, CNO, NP/PA

Presenters

Talbot "Mac" McCormick, MD

Dr. Mac is President and CEO of Eagle Telemedicine and Eagle Hospital Physicians. A board-certified internist, he began as a hospitalist in 2003 and has since served in various physician leadership roles at

Eagle. He practiced internal medicine for 20 years and received his Medical Doctorate from Emory University.

[REGISTER TODAY](#)

How can you build and grow a Telemedicine Program?

This webinar is aimed to help rural healthcare professionals:

- understand the full potential and impact telemedicine makes at a rural facility
- how to get started with telemedicine and quickly grow your program
- what it takes to be a remote provider of telemedicine services

Incorporating these ideas into your current staffing process may prove to be a game changer for your team and your ability to deliver high-quality care.

12 Essential Steps to Building a Telemedicine Program

Date: Wednesday, August 17

Time: 2:00 - 3:00 PM Central Time

Cost: Free

Target Audience: Chief Medical Officer, Chief Nursing Officer, Director of Nursing, Clinicians, Medical Group Manager, Medical Directors, Neurologist

Presenters

David C. Johnson, Certified Telehealth Liasion, Fort Drum Regional Health Planning Organization

Julius Gene S. Latorre, MD, MPH, Medical Director, Upstate University Hospital Comprehensive Stroke Center

Ben Moore, CEO, River Hospital

[REGISTER TODAY](#)

Learn to improve identification and management of HCV in your rural practice.

Join Drs. Paul Kwo and Rajender Reddy in the Webinar, New HCV Testing Policies: Reality for Rural Clinics, as they discuss current HCV testing guidelines, the practicalities of testing in already-busy rural clinics, and the initial steps for evaluating liver health in patients with newly identified HCV.

This webinar is part of a series of educational offerings centered around the needs of the rural healthcare provider. The learning components of the series, which concludes with a master competency examination and certificate recognition, will arm primary care professionals with knowledge and competence specific to rural practice settings and will improve the capacity for high-quality HCV care across the country.

New HCV Testing Policies: Reality for Rural Clinics

Date: Thursday, August 25

Time: 2:00 - 3:00 PM Central Time

Cost: Free

Target Audience: Primary care clinicians who care for patients outside of metropolitan areas

Presenters

Paul Kwo, MD and Rajender Reddy, MD

[REGISTER TODAY](#)

###

“Summer 2016 PDM for Consumers with Medicaid or CHIP MEC: An Overview of for Agents and Brokers”

Agents/Brokers: Register now for the “Summer 2016 PDM for Consumers with Medicaid or CHIP MEC: An Overview of for Agents and Brokers” webinar on August 5

Registration is now open for the “Summer 2016 Periodic Data Matching (PDM) for Consumers with Medicaid or CHIP Minimum Essential Coverage (MEC): An Overview of for Agents and Brokers” webinar scheduled for August 5 at 1:00 PM Eastern Time.

The webinar will provide an overview of the summer 2016 PDM process for consumers enrolled in both a Marketplace qualified health plan with advance payments of the premium tax credit and/or cost-sharing reductions and MEC through Medicaid or the Children’s Health Insurance Program. The webinar will explain how agents and brokers can assist affected consumers.

To register for the webinar, please log in to www.REGTAP.info. Registration closes 24 hours prior to the event.

###

Plan Year 2017 FFM Registration and Training Webinars:

CMS will host two webinars on a recurring basis during the next three months to help you complete plan year 2017 registration and training. While you are welcome to participate in either of these webinar sessions, you may prefer to attend the webinar designed to provide the level of information you need to know. Both webinars will highlight updates to FFM policies and processes since plan year 2016 and will include a web-chat question and answer session immediately following the presentation.

- **“Plan Year 2017 FFM Registration and Refresher Training for Agents and Brokers Returning to the FFMs.”** This webinar will provide an abbreviated review of the registration steps, and describe the new, condensed Refresher Training option available to you if you completed registration in plan year 2016. Webinar dates are:
 - August 3, 1:00 PM – 2:30 PM ET
 - August 10, 1:00 PM – 2:30 PM ET
- **“Plan Year 2017 FFM Registration and Training for Agents and Brokers New to the FFMs.”** This webinar will provide a detailed discussion of registration steps and training requirements to assure you have the information you need to complete all the registration steps, including some steps that returning agents and brokers need not perform. Webinar dates are:
 - August 4, 11:00 AM – 12:30 PM ET

Registration is now open for all webinars at www.REGTAP.info and agents and brokers are only allowed to register for one session. If you have questions on the webinar registration process, visit the "Agent and Broker Webinars" section of the [Agents and Brokers Resources webpage](#) for more information.

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