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Open Enrollment for Health Insurance is Here!

The fourth Open Enrollment for the Health Insurance Marketplace has begun. Americans are able to visit HealthCare.gov to shop for and enroll in an affordable health plan for 2017. In launching open enrollment, HHS Secretary Burwell commented, “This Open Enrollment, we’re encouraging every American who might need coverage to visit HealthCare.gov, where they’ll find options for affordable health insurance. This year, the vast majority of consumers will qualify for tax credits that help keep coverage affordable, and it’s easier than ever to shop around and compare options. As we sound today’s opening bell, let’s also take stock of the historic gains in coverage we’ve made as a country, and work together to continue that progress.”

This year, we’ll be using social media more than ever before to get the word out to consumers to #GetCovered. It’s more important than ever that we share key messages about Open Enrollment:

- Financial help is available to help keep coverage affordable.
- Signing up is easier and faster than ever.
- Help is available! Free, confidential help can be found in person or by phone.
• All consumers will have choices, and can compare plans by total costs, doctor network, or covered prescriptions.

• December 15 is the deadline if you want to be covered at the start of the new year.

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

Specific to our faith-based and community partners, the 2017 Health Care Law Toolkit - PDF can help faith and community leaders learn and educate others about the health care law. You can also check out the Tools for Faith Days of Action for how to be involved in our days of action happening on November 11-13, December 19-23, and January 16-20. Also consider signing up for one of the upcoming Webinars to learn more about the Affordable Care Act.

The HHS Partnership Center is excited to kick off the first Faith and Community Weekend of Action on November 11-13 by highlighting the importance of encouraging men to sign up for affordable health insurance. It’s an opportunity to focus on the health of our fathers, sons, brothers, and friends. To support men’s health and encourage the men in our lives to enroll, we are asking ladies to wear blue at services in faith and community settings during the weekend of November 11th through the 13th. You can use this flyer on our website to increase awareness about Ladies Wear Blue in your community.

Please spread the word about the importance of men’s health and enrolling by taking a picture that weekend wearing blue and sharing your photo on social media using the hashtag #LadiesWearBlue.

###

Biweekly Enrollment Snapshot

**WEEKS 1 AND 2, NOV 1 - 12, 2016**

In weeks one and two of Open Enrollment for the Health Insurance Marketplace for 2017, millions of people came to Healthcare.gov and shopped for quality, affordable plans. Over a million people selected plans using the Healthcare.gov platform since Open Enrollment began November 1, including about 250,000 new consumers and over 750,000 consumers renewing their coverage.

“We are all in for this Open Enrollment and excited that over 1 million people have already signed up for 2017 coverage through HealthCare.gov,” said Department of Health and Human Services Secretary Sylvia Burwell. “The American people are demonstrating how much they continue to want and need the coverage the Marketplace offers, and we are encouraging all Americans who need health insurance for 2017 to visit HealthCare.gov or their state Marketplace and check out their options. Most consumers can find a plan for $75 or less per month, and consumers should enroll by December 15th for coverage that starts January 1st.”

As in past years, enrollment weeks are measured Sunday through Saturday. Therefore, this year, week one was only five days long, from Tuesday to Saturday, and thus this biweekly snapshot covers the first twelve days. There were 53,000 more plan selections during the first 12 days of Open Enrollment this year than last year. Moreover, enrollment accelerated on November 9th, as CMS launched additional outreach. Over 300,000 people selected plans from November 9th through November 11th.

Every two weeks during Open Enrollment, the Centers for Medicare and Medicaid Services (CMS) will release enrollment snapshots for the HealthCare.gov platform, which is used by the Federally-facilitated Marketplaces and
State Partnership Marketplaces, as well as some State-based Marketplaces. These snapshots provide point-in-time estimates of biweekly plan selections, call center activity, and visits to HealthCare.gov or CuidadoDeSalud.gov. The final number of plan selections associated with enrollment activity during a reporting period may change as plan modifications or cancellations occur, such as due to life changes like starting a new job or getting married. In addition, as in previous years, the biweekly snapshot only reports new plan selections, active plan renewals and, starting at the end of December, auto-renewals; it does not report the number of consumers who have paid premiums to effectuate their enrollment.

Later in the Open Enrollment period, HHS will produce more detailed reports that look at plan selections across the Marketplace, including both states using the HealthCare.gov platform and State-based Marketplaces using their own enrollment platforms.

Definitions and details on the data are included in the glossary.

**Federal Marketplace Snapshot**

<table>
<thead>
<tr>
<th>Federal Marketplace Snapshot</th>
<th>Weeks 1 and 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nov 1 – 12</td>
</tr>
<tr>
<td>Plan Selections (net)</td>
<td>1,008,218</td>
</tr>
<tr>
<td>New Consumers</td>
<td>246,433</td>
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<tr>
<td>Consumers Renewing Coverage</td>
<td>761,785</td>
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<tr>
<td>Consumers on Applications Submitted</td>
<td>2,057,759</td>
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<tr>
<td>Call Center Volume</td>
<td>1,247,899</td>
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<tr>
<td>Calls with Spanish Speaking Representative</td>
<td>87,126</td>
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<tr>
<td>HealthCare.gov Users</td>
<td>4,528,675</td>
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<tr>
<td>CuidadoDeSalud.gov Users</td>
<td>133,081</td>
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<tr>
<td>Window Shopping HealthCare.gov Users</td>
<td>1,207,985</td>
</tr>
<tr>
<td>Window Shopping CuidadoDeSalud.gov Users</td>
<td>16,230</td>
</tr>
</tbody>
</table>

**Glossary**

**Plan Selections:** The cumulative metric represents the total number of people who have submitted an application and selected a plan, net of any cancellations from a consumer or cancellations from an insurer that have occurred to date. The biweekly metric represents the net change in the number of non-cancelled plan sections over the two-week period covered by the report.

Plan selections will include those consumers who are automatically re-enrolled into a plan, which occurs at the end of December.

To have their coverage effectuated, consumers generally need to pay their first month’s health plan premium. This release does not report the number of effectuated enrollments.

**New Consumers:** A consumer is considered to be a new consumer if they did not have Marketplace coverage at the start of Open Enrollment on November 1st, 2016.

**Renewing Consumers:** A consumer is considered to be a renewing consumer if they had 2016 Marketplace coverage on November 1st, 2016 at the start of Open Enrollment and either actively select the same plan or a new plan for 2017 or are automatically re-enrolled into a plan, which occurs at the end of December.


Consumers on Applications Submitted: This includes a consumer who is on a completed and submitted application or who, through the automatic re-enrollment process, which occurs at the end of December, had an application submitted to a Marketplace using the HealthCare.gov platform. If determined eligible for Marketplace coverage, a new consumer still needs to pick a health plan (i.e., plan selection) and pay their premium to get covered (i.e., effectuated enrollment). Because families can submit a single application, this figure tallies the total number of people on a submitted application (rather than the total number of submitted applications).

Call Center Volume: The total number of calls received by the call center for the 39 states that use the HealthCare.gov platform over the course of the weeks covered by the snapshot or from the start of Open Enrollment. Calls with Spanish speaking representatives are not included.

Calls with Spanish Speaking Representative: The total number of calls received by the Federally-facilitated Marketplace call center where consumers chose to speak with a Spanish-speaking representative. These calls are not included within the Call Center Volume metric.

HealthCare.gov or CuidadodeSalud.gov Users: These user metrics total how many unique users viewed or interacted with HealthCare.gov or CuidadodeSalud.gov, respectively, over the course of a specific date range. For cumulative totals, a separate report is run for the entire Open Enrollment period to minimize users being counted more than once during that longer range of time and to provide a more accurate estimate of unique users. Depending on an individual’s browser settings and browsing habits, a visitor may be counted as a unique user more than once.

Window Shopping HealthCare.gov Users or CuidadoDeSalud.gov Users: These user metrics total how many unique users interacted with the window-shopping tool at HealthCare.gov or CuidadoDeSalud.gov, respectively, over the course of a specific date range. For cumulative totals, a separate report is run for the entire Open Enrollment period to minimize users being counted more than once during that longer range of time and to provide a more accurate estimate of unique users. Depending on an individual’s browser settings and browsing habits, a visitor may be counted as a unique user more than once. Users who window-shopped are also included in the total HealthCare.gov or CuidadoDeSalud.gov user total.

###

SHOP is Open for Business
Take Advantage of Waived Minimum Participation Rate

The SHOP Marketplace is open for business for 2017! Did you know that from November 15 through December 15, you can enroll your business in SHOP Marketplace coverage without meeting a Minimum Participation Rate (MPR) requirement? This means that you can offer coverage through the SHOP Marketplace even if only a few of your employees accept the coverage. Don’t miss out on this important, limited time opportunity to get a SHOP Marketplace plan! Small businesses can apply for SHOP Marketplace coverage at any month of the year, but starting December 16, employers must meet their state’s MPR to enroll. In most states, 70% of your eligible employees must enroll in the plan(s) you offer or have some other form of health insurance.

Thinking about offering health insurance to your employees? Haven’t had the time to start shopping? Snapshots of the lowest monthly premiums for SHOP Marketplace plans are now available! No account or login information needed.

The SHOP Marketplace makes it easier for small business employers to offer quality, affordable health insurance to their employees.

See how affordable coverage for your business can be.

Have questions? Contact the SHOP Call Center at 1-800-706-7893 (TTY: 711) weekdays from 9 a.m. to 7 p.m. ET, or login to find an agent or broker in your area.

Open Enrollment Updates: 2017 Penalty / Social Media Toolkit / Theme Weeks / Enrollment Projections

2017 Individual Responsibility Payment Amounts

The IRS issued guidance confirming that the 2017 individual shared responsibility payment amount, or the penalty that consumers pay for not having coverage, will remain at the same level as the 2016 fee.

In your work with consumers this season, let them know that if they could’ve afforded health coverage but chose not to buy it and didn’t qualify for an exemption, they may need to pay a fee with their federal tax return.
To learn more about the penalty, click [here](#).

**Open Enrollment Social Media Toolkit for Assistors**

The [Open Enrollment Social Media Toolkit](#) for assisters is now available! Assisters are encouraged to leverage these sample posts, pictures, gifs, and more in your social media education, marketing and outreach efforts.

- Facebook toolkit
- Twitter toolkit
- Instagram tool kit
- Videos & Gifs

Be sure to keep checking the toolkit throughout open enrollment as we continue to update with new items!

**2017 Open Enrollment Theme Weeks**

During Open Enrollment the Marketplace will focus its outreach, education and enrollment efforts on specific populations each week. Assisters are encouraged to support these efforts by tailoring their outreach to focus on these populations during each of the theme weeks listed below.

**November 2016:**
- Week of October 31st: Open Enrollment Has Begun, LEP Week of Action
- Week of November 7th: Open Enrollment Has Begun, Faith Weekend of Action
- Week of November 14th: Rural Health Week of Action, Native American Week of Action
- Week of November 21st: Thankful for Coverage Week of Action, Small Business Saturday Nov. 26th
- Week of November 28th: Private Sector Week of Action

**December 2016:**
- Week of December 5th: LGBT Week of Action, Men’s Week of Action, Philanthropy/Foundations Week of Action
- Week of December 12th: Young Invincibles Week of Action, Providers and Hospitals Week of Action, Deadline push
- Week of December 19th: Give the Gift of Health Care, Faith Week of Action, Women’s Week of Action
- Week of December 26th: Health and Wellness/New Year’s Resolution Week of Action

**January 2017:**
- Week of January 2nd: Health and Wellness/New Year’s Resolution, Men’s Week of Action
- Week of January 9th: Latino Week of Action and State and Local Official Week of Action
- Week of January 16th: African American Week of Action, AAPI Week of Action, and Faith Week of Action
- Week of January 23rd: Deadline Focus
Week of January 30th: Deadline Focus and Strong Final Push in last 2 days

13.8 Million Expected to Sign Up for Marketplace Coverage During Open Enrollment

Last week, Secretary of Health and Human Services Sylvia M. Burwell announced that 13.8 million individuals are expected to sign up for coverage through the Marketplaces during the upcoming Open Enrollment, predicting continued robust growth in the Marketplaces. The projection was announced as part of her remarks highlighting the Affordable Care Act’s success in dramatically expanding access to coverage, and describing the Marketplace’s role in the Administration’s work to create a smarter health care system that puts Americans at the center of their care.

Read the report: Health Insurance Marketplace Enrollment Projections for 2017

Read the press release: First Half of 2016 Effectuated Enrollment Snapshot

Read the Secretary’s remarks: Our Fourth Open Enrollment: The Future of the Marketplace

###

2017 Landscape for Marketplace QHP and SADP Plans by County Now Available

CMS released the Qualified Health Plan (QHP) Landscape for 2017 that displays the available QHPs and Standalone Dental Plans (SADPs) by county in the Health Insurance Marketplace. There are four types of QHP Landscape files available: (1) individual medical marketplace; (2) SHOP medical marketplace; (3) individual dental marketplace; and (4) SHOP dental marketplace. The QHP Landscape provides consumers in the Federally-facilitated Marketplace (FFMs) and State Partnership Marketplace (SPM) states a snapshot of the plans available to them as well as basic information associated with each plan, including estimated premium for selected scenarios and cost-sharing data for selected services. QHP Landscape files were also created for each state that has a State-based Marketplace that uses the HealthCare.gov eligibility and enrollment platform for 2017 (SBM-FP). More information about the landscape is also available in ASPE’s landscape issue brief.

###

Today, CMS released the first bi-weekly Marketplace enrollment snapshot showing net plan selections over the first 12 days of Open Enrollment. Over one million plans were selected – representing an increase of 69,000 over last year.

“We are all in for this Open Enrollment and excited that over 1 million people have already signed up for 2017 coverage through HealthCare.gov,” said Department of Health and Human Services Secretary Sylvia Burwell. “The American people are demonstrating how much they continue to want and need the coverage the Marketplace offers, and we are encouraging all Americans who need health insurance for 2017 to visit HealthCare.gov or their state Marketplace and check out their options. Most consumers can find a plan for $75 or less per month, and consumers should enroll by December 15th for coverage that starts January 1st.”

To find a copy of the Snapshot, visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-16.html

Please help us to amplify on Twitter by retweeting the Secretary using the below:

- **Retweet @SecBurwell:** Over a million people selected plans through @HealthCareGov in the first 12 days of Open Enrollment. #GetCovered
- **Retweet @SecBurwell:** 1M people have already shown us they want their 2017 coverage to start Jan 1, that coverage is something they need and want. #GetCovered
- **Retweet @SecBurwell:** Most can #GetCovered for $75 or less per month. Consumers must enroll by December 15 for coverage that starts January 1.
New Assister Resources
The Standard Operating Procedures Manual for Assisters in the Individual FFM
This Manual is a step-by-step instructional guide for assisters to use when assisting consumers with HealthCare.gov eligibility, enrollment and post enrollment application processes. It contains standard operating procedures that include screenshots and detail the processes for required and authorized assister activities within the Individual FFM. It covers topics like privacy and security guidelines, creating an account, identity verification, paying premiums, and reporting life changes.

The Assister’s Roadmap to Resources
CMS and other federal agencies and non-federal organizations have produced a number of resources to help assisters in their role. The Assister’s Roadmap to Resources should serve as an assister’s directory for the most important of these resources, with clickable links to each resource. This tool provides an overview of important Marketplace and other health coverage topics, provides links to helpful resources on those topics, and contains information that assisters “Need to Know” when helping consumers apply for and enroll in Marketplace and other health coverage.

We have posted Updated Guidance for Navigator Cooperative Agreement Recipients in FFMs: Carrying out Navigator Duties and Activities through Subrecipients or Contractors. These FAQs discuss how an FFM Navigator grantee may carry out its Navigator duties itself, or it may carry out some of these duties through subrecipients or contractors. For example, a recipient might perform all of the Navigator duties except outreach and education, and carry out required outreach and education duties through a subrecipient or contractor that will perform only those functions.

Friday, November 4, 2016 webinar, which included Marketplace Updates, a presentation on Assister Do’s & Don’ts as well as Tips for Avoid DMI’s, can be found at: https://goto.webcasts.com/starthere.jsp?ei=1121403

Program Overviews: Quality Star Rating / Marketplace 101
Quality Rating Information: Pilot Program Overview
For the 2017 individual market open enrolment period, CMS will provide the pilot display of quality star ratings in two FFM States (Virginia and Wisconsin). Our assister webinar on Friday October 14th provided assisters with guidance about CMS’s Health Insurance Marketplace Quality Star Rating pilot program to help assisters educate enrollees about the Marketplace quality ratings, advise enrollees on how to use the quality ratings to compare qualified health plans (QHPs) in their Marketplaces, and answer questions from enrollees about the Marketplace quality ratings.

The quality ratings provide another way for consumers to compare qualified health plans offered through the Marketplace rating the quality of health services and enrollee experience. In addition, these ratings give consumers a snapshot of the quality of available QHPs offered through the Marketplace in their state and objective information on how the QHPs perform in the Marketplace. The goal of the pilot program is to get feedback from consumers about their experience using the Marketplace quality ratings and to help CMS improve and refine the display of quality ratings before nationwide public reporting. Consumers in non-pilot program states whose consumers use HealthCare.gov won’t see quality ratings displayed for QHPs offered through the Marketplaces on HealthCare.gov in 2017.
The slide deck from this presentation can be found here and the report on the new QRS pilot program can be found on CCIIO’s website here.

###

**Marketplace 101 Overview**

Is this your first year working as an assister? Need a refresher on the Marketplace? Check out “Marketplace 101” which provides a high-level overview of the Affordable Care Act and the Health Insurance Marketplaces, with a focus on the Federally-facilitated Marketplace, including State-Partnership Marketplaces. The presentation explains the Health Insurance Marketplace, reviews who might be eligible, defines options for those with limited income, explains the enrollment process, explains available options for people with Medicare, and helps locate helpful resources. Check out our training resources posted on www.marketplace.cms.gov for the “Marketplace 101” slide deck here, or the “Health Insurance Marketplace 101” recorded webinar here.

**What Consumers Need to Know about the Employer Notice Program and Appeals Process**

Assisters should be prepared to help consumers who may have received a notice from the Marketplace about an employer appeal. Consumers may want to take action to either contest the employer during the appeals process if they disagree with the employer, or to update their Marketplace application if they agree with the employer. This will help ensure the consumer receives the correct eligibility going forward.

**What are employer notices?**

Consumers who are eligible for affordable, minimum value coverage from an employer (even if they decline their employer’s coverage) or who are enrolled in their employer’s plan are NOT eligible for APTC or CSRs. Earlier this year, the Marketplace sent notices to some employers if they had an employee who enrolled in a Marketplace plan with APTC or 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
- the employee was in a waiting period and unable to enroll in health care coverage.

The notice to the employer explained that the employer can appeal to the Marketplace Appeals Center on the basis that the employer did offer the employee affordable, minimum value ESC and/or the employee is enrolled in the employer’s coverage, and therefore the employee is not eligible for APTC or CSRs.

**What can an employee (i.e. the Marketplace consumer) do if his or her employer appeals to the Marketplace in response to an employer notice?**

When the Marketplace Appeals Center accepts an employer’s appeal, the employee will receive a notice and will be given the opportunity to submit evidence to support their attestation that they didn’t have access to, affordable, minimum value ESC. If an employee (the consumer) **doesn’t agree** with the employer that he or she has an offer of affordable, minimum value ESC, then he or she can submit evidence that he or she didn’t have an offer of affordable, minimum value ESC and therefore is indeed eligible for APTC or CSRs.

Example: An employee may submit evidence of household income and the premium amount for the lowest cost self-only plan offered by their employer to demonstrate that the ESC plan was not affordable. Good examples of evidence includes a paystub to document income, any documents that show what health plan options employees have available to them, and/or the Summary of Benefits and Coverage (SBC) from their ESC plan to show it does not meet minimum value standards.
In some cases, an employee may agree that he or she does have an offer of affordable, minimum value ESC. This might happen if the employee didn’t have correct information about his or her ESC when applying for Marketplace coverage. If an employee receives a notice about a Marketplace employer appeal and agrees that he or she does have an offer of affordable, minimum value ESC, the employee should update his or her Marketplace application right away. This could help reduce the consumer’s potential tax liability (or of the tax filer in the consumer’s household, if the consumer is not the tax filer). The employee will also have a right to appeal any eligibility redetermination that results from updating their application after reporting their eligibility for affordable, minimum value ESC.

For additional information on employer notices and appeals:


###

**Marketplace Assister Call Lines**

Similar to the previous open enrollments, there will once again be a designated call center line for Assisters. This year the line features several enhancements designed to help better streamline the call process. Utilizing the Assister line will only allow Assisters to bypass the regular call center line if they need help with password resets or accessing certain call center-initiated SEPs. This enhancement is designed to help minimize the time they have to spend on the phone trying to resolve certain consumer issues. For all other issues, the wait time will be the same as the regular call center line.

The Call Center will be tracking the topics assisters request assistance with through the designated assister lines. We encourage assisters to use the assister line when working with consumers not only to receive enhanced service, but also in order to enable the Call Center to better monitor and meet assisters’ needs. Please note there are two different Assister lines, one for Navigators and one for CACs:

Assister Line for Navigators: **1-855-868-4678**

Assister Line for CACs: **1-855-879-2683**

If Assisters are having difficulty accessing the Assister line, please reach out to your project officer if a Navigator, or email the [CACInbox@cms.hhs.gov](mailto:CACInbox@cms.hhs.gov) if you are a CAC. CCIIO will verify that the code you are utilizing matches our records.

###

**Standing Assister Resources: Helpful Links / Call Center Hours / Contact Us**

**Links to Helpful Resources**

- Marketplace Assister Training [Resources](#) and [Webinar](#)
- [Technical Assistance Resources](#)
- CMS Marketplace [Applications & Forms](#)
- CMS [Outreach and Education](#) Resources
- [Marketplace.CMS.gov Page](#)
- [CMSzONE Community Online Resource Library Pilot for Marketplace Assisters](#)
Marketplace Call Center and Shop Center Hours
Health Insurance Marketplace Call Center: 1-800-318-2596 (TTY: 1-855-889-4325). For customer service support, to start or finish an application, compare plans, enroll or ask a question. Available 24 hours a day, 7 days a week. Closed Memorial Day, July 4th, and Labor Day. CACs and Navigators should call their dedicated phone lines so the Call Center can better track the needs of assisters. The dedicated Assister Line can also help with password resets and can help with access to non-application SEPs. Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs) for more information on the Assister Line.

Navigator Marketplace Call Center line: 1-855-868-4678
CAC Marketplace Call Center line: 1-855-879-2683
SHOP Call Center: For customer service support, including assisting employers and employees apply for and enroll in SHOP. 1-800-706-7893 (TTY: 711). Available M-F 9:00 am-7:00 pm EST. Closed New Year’s Day, Martin Luther King Day, Memorial Day, July 3rd, Labor Day, Veterans Day, Thanksgiving and the day after, and Christmas.

###

2017 Marketplace Open Enrollment and Beyond
While there has been much discussion about the future of the Affordable Care Act and the impact of the Presidential election, there have been no changes to the law. In your work with consumers, let them know that the outcome of the 2016 presidential election doesn’t impact their ability to enroll in affordable Marketplace coverage, the plans available to consumers, and the savings consumers are eligible for. The outcome of the 2016 presidential election also doesn’t change or end consumer Medicare/ CHIP/ Medicaid coverage.

On November 10, HHS Press Secretary Marjorie Connolly said, “We are all in for this Open Enrollment, and we continue to execute a robust outreach strategy with partners across the nation to let Americans know affordable coverage is available and that they should enroll by December 15th for coverage that starts January 1st. We’re encouraging anyone who might need coverage for 2017 to visit healthcare.gov to check out their options—most can find a plan for $75 or less per month. This is coverage that is vital to millions of Americans, and that is being proven yet again as more people sign up, including yesterday, when more than 100,000 people signed up for coverage, the highest single-day total so far during this Open Enrollment.”


###

OE Snapshot: Over One million Plans Selected in the first 12 days
Today, CMS released the first bi-weekly Marketplace enrollment snapshot showing net plan selections over the first 12 days of Open Enrollment. Over one million plans were selected – representing an increase of 69,000 over last year.

“We are all in for this Open Enrollment and excited that over 1 million people have already signed up for 2017 coverage through HealthCare.gov,” said Department of Health and Human Services Secretary Sylvia Burwell. “The American people are demonstrating how much they continue to want and need the coverage the Marketplace offers, and we are encouraging all Americans who need health insurance for 2017 to visit HealthCare.gov or their state Marketplace and check out their options. Most consumers can find a plan for $75 or less per month, and consumers should enroll by December 15th for coverage that starts January 1st.”

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Every two weeks during Open Enrollment, CMS will release enrollment snapshots for the HealthCare.gov platform, which is used by the Federally-facilitated Marketplaces and State Partnership Marketplaces, as well as some State-based Marketplaces. These snapshots provide point-in-time estimates of biweekly plan selections, call center activity, and visits to HealthCare.gov or CuidadoDeSalud.gov.


###

**Update/New Information on Resolving DMIs and Tips for Preventing Them**

A) Resolving Data Matching Issues (DMIs)

On November 4th, we provided additional information in response to questions from assisters about how to resolve DMIs. It is important that consumers understand how and when to submit the requested information and the timeline to do so when they receive a notice from the Marketplace saying that they need to send documentation for eligibility verification purposes. The Marketplace contractor works DMI cases in the TIPS task tool as indicated in the workflow below.

For most consumers, the Marketplace immediately verifies the information submitted on their application. But in some cases, the information the applicant provides does not match existing records from trusted data sources (TDS) such as IRS, SSA, DHS, etc. or the applicant does not provide enough information to match existing records from TDS. Under those circumstances, the application generates a DMI, and consumers are given 90/95 days to submit documentation to verify their application information.

It is important to note that temporary eligibility for Marketplace coverage and financial assistance can be granted during the 90/95 days inconsistency period. During that time the consumer should submit supporting documentation to resolve a DMI. If consumers fail to submit information within the 90/95-day window they risk losing their Marketplace health care coverage and/or having their financial assistance adjusted, in some cases to $0. For example, consumers with citizenship/immigration DMIs will be terminated from coverage if they do not submit the requested
information, and consumers with annual income DMIs will have their APTCs/CSRs re-determined based on available tax data. When Marketplace coverage is terminated as a result of an unresolved DMI, consumers may be liable for any advanced premium tax credits (APTCs) and/or cost sharing reductions (CSRs) they received during the 90/95-day period.

**Consumer Outreach**

If a DMI is unresolved, consumers will receive 90-day, 60-day, and 30-day warning notices as well as a 15-day reminder call before their DMIs are set to expire. These notices will be mailed in English or Spanish based on the consumer’s language preference. We encourage assisters to help consumers review their Marketplace DMI notices to identify what documents the Marketplace needs, and help them determine whether or not they have submitted sufficient supporting documentation.
**B) Steps to Help Resolve DMIs**

In many instances, DMIs are generated due to missing or incorrect information on the application. The most common mistakes producing DMIs are:

1. A consumer failed to provide a Social Security Number (SSN) on their application.
2. A consumer failed to provide all household income on the application.
3. A consumer’s name used for their application differs from how it appears in his or her citizenship document or other document.
4. A consumer failed to provide his or her immigration documents and ID numbers.

We strongly recommend that assisters work with consumers to reduce confusion, clarify and simplify the DMI process, improve document collection and submission, and negate the potential for disruptions in coverage. In cases that do require follow-up, assisters should follow these steps to help consumers resolve DMIs:

- Help confirm if the consumer has a DMI through My Account and notices;
- Help the consumer go back to the application to confirm the information that is included is correct; and
- Help the consumer submit document(s) online or by mail to resolve his or her DMI.

**C) Preventing DMIs**

The following FAQs provide general information on how to prevent all DMI types:

**Q1: What can an assister do to reduce cases that trigger DMIs?**

A1: As assisters, you can help to review a consumer’s Marketplace application to verify that he or she:

- Completes all possible fields in the application;
- Corroborates that the consumer’s name exactly matches documents such as his or her social security card;
- Provides information on the application that is complete and free of errors or typos; and
• Includes non-applicant(s) SSN(s) to accurately estimate applicant household income

Q2: How can consumers prevent citizenship/immigration DMIs from occurring?

A2: To prevent consumers from receiving a citizen/immigration DMIs, assisters should:

- Encourage consumers to select an appropriate immigration document type, and provide all documents numbers and ID numbers;
- Reassure consumers that immigration information will only be used by the Marketplace and will not be used for immigration enforcement purposes; and
- Be aware that consumers not seeking health coverage for themselves do not need to provide their citizenship or immigration status.

Q3: How can assisters help consumers to prevent other types of DMIs?

A3: a) For Annual Income DMIs

- In order for the Marketplace to match annual household income data on an application with IRS data, the household must have filed taxes; and
- Not everyone is required to file taxes, but those who have not filed will likely have a DMI and need to submit documents.

b) For Minimal Essential Coverage DMIs

- Confirm that the applicants do not have other coverage and that any previous coverage has definitely ended.

c) American Indian/Alaska Native DMI

- Double-check that the applicant is a member of a Federally-recognized tribe, not solely a State-recognized tribe, since State tribe members are not eligible for special financial assistance.
- Everyone who claims to be a member of a Federally-recognized tribe will get a DMI and must submit documents to receive special financial assistance.

For more information about how to prevent and resolve DMIs, please refer to the following documents:

Five Things Assisters Should Know About Data Matching Terminations Factsheet: 

Preventing and Resolving Data-Matching Issues in the FFM

Assister Dos and Don’ts in Federally-facilitated Marketplaces

On Friday, November 4, we presented an overview of Assister Dos and Don’ts in Federally-facilitated Marketplaces, including application and enrollment assistance; outreach and education; avoiding conflicts of interest; and providing nondiscriminatory, culturally and linguistically appropriate services, and services accessible for consumers with disabilities. Below is a refresher on the dos and don’ts for providing application and enrollment assistance:

Assisters must provide information in a fair, accurate, and impartial manner to everyone who seeks your help. To provide fair, accurate, and impartial information, you must:

- Provide information that helps consumers submit a Marketplace eligibility application for coverage and financial assistance
- Provide comprehensive information about the substantive benefits and features of a plan
- Help consumers find plans with cost-sharing reductions or other federal financial assistance, if they are eligible
- Clarify distinctions among coverage types, including QHPs, Medicaid and CHIP
- Make sure consumers make their own informed choices about which coverage option best meets their needs and budget
- Make sure the acts of selecting, applying for, and enrolling in a plan stay in the consumers’ hands

To provide fair, accurate, and impartial information, you must not:

- Log into the consumer’s online Marketplace account, fill out the Marketplace application, or select a plan on your own
- Recommend that a consumer select a specific plan or set of plans
- Refer a consumer to any specific agent or broker or any specific set of agents or brokers

When providing assistance related to your duties as an assister, you must not:

- Charge consumers for assistance
- Receive compensation from your organization on a per-application, per-individual-assisted, or per-enrollment basis
- Receive consideration from a health insurance issuer (or issuer of stop loss insurance) in connection with enrolling a consumer in a QHP or non-QHP

We will share the slides from this presentation when they are available. In the meantime, assisters should check out these resources on assister duties:

- Application and Enrollment Assistance

Outreach and Education

Conflict of Interest Requirements

Working with agents and brokers

Assister Conflict of Interest Requirements (slides with speaker notes)

Providing Nondiscriminatory, Culturally and Linguistically Appropriate Services, and Services Accessible for Consumers with Disabilities

Training Materials for Section 1557

###

**IRS FAQs on Employer Sponsored Coverage and Premium Tax Credits**

Under IRS and Marketplace rules, a consumer who is eligible for employer sponsored health coverage (ESC) that is considered affordable and meets minimum value standards is not eligible for advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs) through the Marketplace. More information on minimum value and what it means to be affordable is available at [www.healthcare.gov/glossary/affordable-coverage/](http://www.healthcare.gov/glossary/affordable-coverage/) and [www.healthcare.gov/glossary/minimum-value/](http://www.healthcare.gov/glossary/minimum-value/).

The IRS recently released two new FAQs related to eligibility for the premium tax credit (PTC) for consumers who appear to be eligible for affordable, minimum value ESC through their job or through their spouse’s job. The new FAQs, numbers 13 and 14, are available at [www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit#Eligibility](http://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit#Eligibility).

The new FAQs explain that for the purposes of eligibility for advance payments of the premium tax credit (APTC), which is received up front by applying through the Marketplace, and the premium tax credit (PTC), which is received and reconciled through the Federal income tax filing process —

- FAQ 13: A consumer is considered **not** eligible for ESC if the consumer appears to have an offer of affordable, minimum value ESC, but the consumer will be fired if he or she tries to enroll in it.

- FAQ 14: A consumer is considered **not** eligible for ESC if the consumer appears to have an offer of affordable, minimum value ESC **through a spouse**, but the spouse will be fired if he or she tries to enroll the consumer in the ESC.

What Assisters should know about consumers who experience a situation described in FAQs 13 and 14:

- They may be eligible for APTC and CSRs (if they meet all other eligibility criteria).

- They should answer “no” to the following Marketplace application questions:

  - “Is [applicant name] currently eligible for health coverage through a job (even if it’s through COBRA or from another person’s job, like a spouse)?”

  - “Will [applicant name] be eligible for health coverage through a job during [coverage year] (even if it’s through COBRA or from another person’s job, like a spouse)?”

- The tax filer in the consumer’s household may be eligible for PTC on the consumer’s behalf.

Note: Consumers who believe they have been fired (or otherwise discriminated against) based on race, color, religion, sex (including pregnancy, gender identity, and sexual orientation), national origin, age (40 or older), disability, or genetic information can file a charge of discrimination with the U.S. Equal Employment Opportunity Commission. More information is available at [https://www.eeoc.gov/employees/charge.cfm](https://www.eeoc.gov/employees/charge.cfm). Consumers may also have other resources and remedies available through their state.

###
What’s new with Find Local Help?
CCIIO has changed our requirements for approving assister organizational listings on Find Local Help. This change supports our data management efforts as we track all listings by Navigator grantees, Certified Application Counselor designated organizations, or Enrollment Assistance Program (EAP) organizations.

As you submit requests to add or update information on Find Local Help, be sure to include all required data elements:

- Organization Name/Affiliation (name of the Navigator grantees organization, the name of Certified Application Counselor Designated Organization (CDO), or the name of an EAP organization)
- Location Name (location name that will be displayed on the Find Local Help website)
- Street Address, City, State, Zip Code
- Phone Number
- Days and Hours of Operation

You may find UPDATED guidance in our Find Local Help Quick Reference Guide and most recent Assister training on how to use the upkeep tool:


###

November is Native American and Alaskan Heritage Month

November is Native American and Alaskan Heritage Month and the first month of 2017 open enrollment for health insurance coverage through the Marketplaces. Aply the theme for heritage month observance is “Serving Our Nations: Health and Wellness Across the Generations.” Read the Presidential Proclamation on Native American Heritage Month and plan an ACA outreach event in your community!

This month’s heritage celebration presents a great opportunity for ACA Assister outreach because November is also a time when many Native Americans participate in cultural events, such as fall harvest festivals and powwows. Links to helpful OE4 resources on American Indian and Alaska Native (AI/NA) outreach are below. And remember, OE4 Native American Week of Action began on November 14!

OE4 Resources on AI/NA Outreach:

- Marketplace.CMS.gov Outreach & Education Materials on Special Populations - American Indian/Alaska Natives
- Tribal Health Reform Resource Center – ACA Webpage
- 2017 Open Enrollment Toolkit for Assisting American Indians and Alaska Natives
- ACA Toolkit for Native Youth
- ACA Elders Initiative
- ACA Three Things You Should Know
### Answers to Assister Questions

**Q:** Do consumers have to include race/ethnicity information on the application? If so, why is this information important?

**A:** Consumers are not required to include information about their race/ethnicity on their application for Marketplace coverage. However, the family and household section of the application does include an optional question that asks consumers to share information on their race/ethnicity. Answers to this question help the Marketplace better understand who is applying for coverage and improve our work with different populations. Assisters can remind consumers that providing this information, or choosing not to provide it, will NOT impact consumers’ eligibility for health coverage in any way.

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### CMS Launches New Online Tool to Make Quality Payment Program Easier for Clinicians

The Centers for Medicare & Medicaid Services (CMS) released a tool to share automatically electronic data for the Medicare Quality Payment Program. This new release is the first in a series that will be part of CMS’s ongoing efforts to spur the creation of innovative, customizable tools to reduce burden for clinicians, while also supporting high-quality care for patients.

In October, CMS released the [Quality Payment Program website](#), an interactive site to help clinicians understand the program and successfully participate. Today’s release, commonly referred to as an Application Program Interface (API), builds on that site by making it easier for other organizations to retrieve and maintain the Quality Payment Program’s measures and enable them to build applications for clinicians and their practices. The API, available at qpp.cms.gov/education, will allow developers to write software using the information described on the Explore Measures section of QPP.cms.gov. Based on interviews with clinicians, CMS created the Explores Measures tool, which enables clinicians and practice managers to select measures that likely fit their practice, assemble them into a group, and print or save them for reference. Already, tens of thousands of people are using this tool.

Dr. Kate Goodrich, Director of the CMS Centers for Clinical Standards and Quality said, “The API released today will continue CMS’s focus on user-driven design by providing developers and our partners the opportunity to turn our data into powerful applications. CMS is committed to collaborating with the organizations that doctors trust to make their lives easier, while supporting their efforts to improve the quality of care across America.”

“An important part of the Quality Payment Program is to make it easier and less expensive to participate, so clinicians may focus on seeing patients,” said Andy Slavitt, Acting Administrator of CMS. “This first release is a step in that process, both for physicians and the technologists who support them.”

Several groups have applauded the release of this information, including: the American Academy of Ophthalmology, the Network for Regional Healthcare Improvement (NHRI), American College of Radiology (ACR), American College of Physicians (ACP), National Rural Accountable Care Consortium, Great Lakes PTN, Pacific Business Group on Health, Compass PTN, TMF QIN-QIO, and the Mountain Pacific Quality Health Foundation.

“The American College of Physicians (ACP) supports the efforts of CMS to design and share publicly accessible interfaces that help simplify the process of physician participation in the Quality Payment Program. These efforts are aligned with ACP’s ongoing efforts to help equip physicians with tools and support needed to transform from volume-based, to value-based, patient-centered care,” said Nitin S. Damle, MD, MS, MACP, president, ACP.

“As a Quality Innovation Network- Quality Improvement Organization, TMF is excited about this innovative approach towards providing transparency around quality improvement efforts. We believe that the API approach will allow CMS, providers, and patients to benefit from the ideas of creative programmers across the country as they
build user-friendly interfaces to put information at the fingertips of those who need it,” said Russell Kohl, MD, FAFP, Medical Director for Practice Transformation, TMF QIN-QIO. “Efficiencies like these, that allow physicians to spend less time on administration and more on caring for patients, are the hallmark of our daily efforts to help caregivers, regardless of their location, provide the best care to patients, and we look forward to seeing CMS’s results.”

“We applaud CMS for using innovations in technology to help clinicians select and report meaningful measures for the quality of care patients receive,” said Debra L. Ness, president of the National Partnership for Women & Families. “APIs hold a lot of promise for helping consumers access and use information in a more actionable and easy-to-understand way, which can lead to improved outcomes for both patients and health care providers.”

Through streamlined policy and improved technology and operations, the Quality Payment Program is modernizing Medicare to pay smarter for better care. The Quality Payment Program is designed to reduce reporting burden on clinicians so that they can focus on their patients, while also providing useful information to clinicians and other stakeholders, so that overall care quality improves. As the program and its supporting website mature, CMS will continue to release data and APIs to spur innovation and keep participants up-to-date.

To see the API Swagger documentation, please visit: https://qpp.cms.gov/api/

###

New Fact Sheets Now Available
A number of new Fact Sheets are now available on the Education page of the Quality Payment Program website. The new Fact Sheets are:

AMP-Related Fact Sheet:
- [How to Design an APM](https://qpp.cms.gov/api/)

MIPS-Related Fact Sheets:
- [Measure Specifications](https://qpp.cms.gov/api/)
- [Measures Specifications Implementation Guide](https://qpp.cms.gov/api/)
- [Measures Specifications Download (232 MB)](https://qpp.cms.gov/api/)

Registries and Qualified Clinical Data Registries (QCDRs) Fact Sheets:
- [Qualified Registry Self-Nomination](https://qpp.cms.gov/api/)
- [QCDR Self-Nomination](https://qpp.cms.gov/api/)

###

Co-Branded Training with CMS
We anticipate that many membership organizations would like to share Quality Payment Program information with their membership, either hosting a webinar on their own or inviting CMS to participate. We would like organizations to consider co-branding their Quality Payment Program training materials with CMS – lending assurance to your membership that this is the official information on the Quality Payment Program.

If you are interested in this opportunity, email Partnership@cms.hhs.gov and put “QPP Education” in the subject line. Include pertinent information about how often you plan to offer the webinar(s), the typical size of your audience, etc. As a reminder, this is a no-cost effort – and any use of CMS materials would be solely for no-cost trainings for your membership. Upon receipt of your request, CMS will send our co-sponsorship agreement to your organization.

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Even if you aren’t interested in co-branding, there are many educational materials available for your use at https://qpp.cms.gov/. Please also contact us if you plan to use these materials without co-branding – we’d like to know how the materials are being used and the audiences being reached.

###

Submit a Formal Comment
CMS encourages the public to submit comments on the MACRA final rule. Comments are due no later than 5 p.m. on December 19, 2016, and can be submitted in several ways, including:

- Electronically via https://www.regulations.gov
- By regular mail
- By express or overnight mail
- By hand or courier

Review the executive summary of the final rule for mailing addresses.

###
MACRA/Quality Payment Program (QPP) Updates

CMS launches new online tool to make Quality Payment Program easier for clinicians

The Centers for Medicare & Medicaid Services (CMS) released a tool to share automatically electronic data for the Medicare Quality Payment Program. This new release is the first in a series that will be part of CMS’s ongoing efforts to spur the creation of innovative, customizable tools to reduce burden for clinicians, while also supporting high-quality care for patients.

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To see the API Swagger documentation, please visit: https://qpp.cms.gov/api/

###

**CMS Releases Changes to the Medicare and Medicaid EHR Incentive Programs**

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2017. This [final rule with comment period](https://www.cms.gov/Regulations-and-Guidance/Rules-Regulations-Federal-Register/2017-Final-Rules/2017-OPPS-ASC-Final-Rule.html) includes a number of proposed changes that would affect the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The final rule will be published on November 14 and comments will be accepted until December 31.

The changes to the Medicare and Medicaid EHR Incentive Programs include:

- For eligible hospitals, CAHs and dual-eligible hospitals attesting to CMS, eliminating the Clinical Decision Support (CDS) and Computerized Order Entry (CPOE) objectives and measures beginning in 2017, reducing a subset of thresholds for the remaining objectives and measures for Modified Stage 2 in 2017 and Stage 3 in 2017 and 2018, and adding new naming conventions to measures for Modified Stage 2 and Stage 3.
- Allowing all returning participants in the EHR Incentive Programs to report on a 90-day EHR reporting period in 2016 and 2017.
- An application process for a one-time significant hardship exception to the Medicare EHR Incentive Program for certain eligible professionals in 2017 who are also transitioning to the Merit-based Incentive Payment System (MIPS).

**For More Information**


###

**NRHA outlines what MACRA means to you**

Providers in rural America need to be aware of changes coming as a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). NRHA has extensively reviewed the rule and outlined what rural physicians and providers must know and consider. NRHA has been participating in the process since the inception of MACRA to ensure rural practices were considered, working with lawmakers and regulators to advocate for rural providers. Learn more about MACRA’s impact on rural directly from policymakers and experts at NRHA’s [Rural Health Policy Institute](https://www.nrha.org/policy) Feb. 7-9, 2017.

###

**Receive Quality Payment Program Email Alerts**

Subscribers of the EHR listserv are encouraged to sign up for the new CMS Quality Payment Program listserv.

The Quality Payment Program is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and includes two tracks—Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).
MIPS will replace three Medicare reporting programs:

- the EHR Incentive Program (Meaningful Use)
- the Physician Quality Reporting System
- the Value-Based Payment Modifier

The Quality Payment Program listserv will provide news and updates on:

- New resources and website updates
- Upcoming milestones and deadlines
- CMS trainings and webinars

The Quality Payment Program’s first performance period opens on January 1, 2017 and closes December 31, 2017. Participation in MIPS can start as early as January 1, 2017 or as late as October 2, 2017. The first payment adjustments based on performance go into effect on January 1, 2019. Subscribe to the Quality Payment Program listserv to receive reminders for all of these important deadlines.

To subscribe, visit the Quality Payment Program portal and select “Subscribe to Email Updates” in the footer. The Education & Tools page includes program resources to help you learn more about eligibility and how to participate.

###

Quality Payment Program Presentations Now Available Online

Two recently presented external slide decks are now available online for your review:

- High-level overview of the Quality Payment Program (presented on October 26)
- Medicare Shared Savings Program (SSP) in the Quality Payment Program (presented on October 27)

###

Submit a Formal Comment on the MACRA Final Rule

CMS encourages the public to submit comments on the MACRA final rule. Comments are due no later than 5 p.m. on December 19, 2016, and can be submitted in several ways, including:

- Electronically via https://www.regulations.gov
- By regular mail
- By express or overnight mail
- By hand or courier

Review the executive summary of the final rule for mailing addresses.

###

Questions about the Quality Payment Program

Have a specific question about the Quality Payment Program? Please e-mail QPP@cms.hhs.gov.

###
Medicare and Medicaid Updates

An Important Message to Medicare Beneficiaries About Supplier of Diabetes Testing Supplies:
According to our records, you’ve received diabetes testing supplies from Arriva Medical. Starting on November 4, 2016, Medicare won’t pay for diabetes testing supplies that Arriva Medical delivers to your home.
If you want Medicare to continue paying for diabetes testing supplies that are delivered to your home, you’ll need to switch to a Medicare national mail-order contract supplier. When you switch suppliers, you might need to have your current prescription transferred or get a new prescription for diabetes testing supplies from your doctor.

How can I find a national mail-order contract supplier online?
Follow these steps:
1. Go to Medicare.gov/supplier
2. Enter your ZIP code, and click “Go”
3. Choose “Mail-Order Diabetic Supplies” in the Competitive Bid Categories section
4. Click the “Search” button at the bottom of the screen

How can I find a national mail-order contract supplier that offers the brand of diabetes testing supplies I use?
You can find a supplier online who offers a specific brand of diabetes testing supplies.
Follow the steps above and:
☐ Enter the brand in the “Search for model (brand)” box on the right of the screen
☐ Click the “Update Results” button

Or, you can call 1-800-MEDICARE (1-800-633-4227) and a customer service representative can assist you. TTY users can call 1-877-486-2048.

NOTE: If you don’t want diabetes testing supplies delivered to your home, you can buy them at any local store (local pharmacy or storefront supplier) that’s enrolled with Medicare. Local stores may charge you more. If you get your supplies from a local store, check with the store to see what your payment will be. You might need to have your current prescription transferred or get a new prescription for diabetes testing supplies from your doctor.

If you have questions about the program or about which supplier you can use, call 1-800-MEDICARE.

###

Medicare Fraud Q&As

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

A. Health care fraud drives up costs for everyone in the health care system. Fraud schemes often depend on identity thieves getting hold of people’s Medicare numbers. So guard your Medicare number. Treat it as you would a credit card.

(Please note that most Medicare Health Plan marketing materials that you receive in the mail are legitimate promotions to educate you on the different Medicare Health Plan options in your area as they are companies who contract with the federal Medicare agency to provide options.)

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

If a sales representative or other provider does any of the following, please know that you can and should report them:
• Knocks on your door or calls you uninvited and tries to sell you a product or service.
• Sends you products through the mail that you didn’t order. You should refuse the delivery and/or return it to the sender. Keep a record of the sender’s name and the date you returned the items.
• Contacts you about Medicare plans unless you gave them permission.
• Offers you “early bird discounts” or “limited time offers.” There are no early bird discounts.
• Claim that you need to “act now for the best deal.”
• Offers you free expensive gifts, free medical services, discount packages or any offer that sounds “too good to be true.” (promotional items you’re offered to enroll in a plan must be worth no more than $15, and these items can’t be given on the condition that you enroll in a plan.

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

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

Q. Is the Federal Medicare agency ever going to replace Medicare cards, for beneficiary protection, as they currently contain Social Security numbers?

A. The Medicare Access and Children’s Health Insurance Program, CHIP Reauthorization Act (MACRA) of 2015 requires the Centers for Medicare & Medicaid Services, CMS, to remove Social Security Numbers (SSNs) from all Medicare cards.

The goal is to improve the integrity of the Medicare Program and decrease beneficiary vulnerability to identity theft with minimum disruption and inconvenience to all those impacted.

Why’s this initiative important? When we replace the SSN on all Medicare cards, we can better protect:
• Private financial information
• Federal health care benefit and service payments

However, it is important that Medicare beneficiaries know that new Medicare cards, with the new numbers, will not be issued before April 2018.

Any calls or contacts made to Medicare beneficiaries now or in the near future about replacing their Medicare card will not be official calls, and are potentially fraudulent calls.

The new Medicare Beneficiary Identifier, (MBI) will be a random number generated by CMS and is anticipated to be the same length as the current Health Insurance Claim Number (HICN).

It will take time for CMS to effectively modify more than 75 existing systems that currently use the SSN-based identification system, and to change over to a randomly generated Medicare Beneficiary Identifier (MBI) system, in a cost-efficient way.
CMS expects this work to be completed by the end of 2017 and will solicit input from stakeholders at various points throughout the project to ensure a smooth transition that maintains beneficiaries’ access to care while avoiding disruptions to the payment process.

CMS will also conduct extensive outreach and education for beneficiaries, providers, private insurers, clearinghouses, Medicare contractors, state Medicaid agencies, and other stakeholders before new cards are mailed to beneficiaries.

Again, currently our message to Medicare beneficiaries is you do not need to do anything. Starting in 2018, you’ll get information letting you know about the new Medicare card with a randomly-generated Medicare number. This information will explain how to use the new Medicare card, and what to do with your old card.

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

###
CMS Announces $66.1 Million to Support Zika Prevention & Treatment Services

Today, the Centers for Medicare & Medicaid Services (CMS) announced a funding opportunity providing up to $66.1 million available to support prevention activities and treatment services for health conditions related to the Zika virus. Congress authorized this funding in the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act (P.L. 114-223).

“This funding will accelerate efforts to provide access to important health care services for people, in particular pregnant women and children, living in areas with local active Zika transmission,” Vikki Wachino, Deputy Administrator, CMS, Director CMCS. “Providing immediate assistance to areas affected by Zika is critical. Strong coordination by health departments is essential to address the prevention and treatment needs of people at risk from Zika.”

In accordance with the Zika Response and Preparedness Act (P.L. 114-223), entities eligible to apply for this funding opportunity include states, territories, tribes or tribal organizations with active or local transmission of the Zika virus, as confirmed by the Centers for Disease Control and Prevention (CDC). The CDC has designated American Samoa, Puerto Rico, the U.S. Virgin Islands, and Florida as areas with laboratory-confirmed active or local Zika virus transmission. As such, this emergency funding opportunity is currently available to the territorial and state health departments in these areas.

Through this funding opportunity, up to $66.1 million is available, with $60.6 million directed to Puerto Rico, which has a high incidence of local Zika cases. Allocations are based on the percent of active and local Zika cases reported by the CDC and the size of the populations in these areas. Funding in Puerto Rico will significantly increase the resources and capacity needed to prevent transmission of the virus and provide critical diagnostic, screening and treatment for pregnant women, newborns and others.

To ensure a rapid Zika response, applicants must demonstrate their ability to quickly and efficiently expand existing Zika response efforts and further determine the most effective use and dissemination of funds in their respective jurisdictions. Funds will be available for health care services related to family planning, diagnostic testing, screening and counseling, medical care, case management and treatment, and improving provider capacity and capability.

###

2017 Medicare Parts A & B Premiums and Deductibles Announced

Today, the Centers for Medicare & Medicaid Services (CMS) announced the 2017 premiums for the Medicare inpatient hospital (Part A) and physician and outpatient hospital services (Part B) programs.

**Medicare Part B Premiums/Deductibles**

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

On October 18, 2016, the Social Security Administration announced that the cost-of-living adjustment (COLA) for Social Security benefits will be 0.3 percent for 2017. Because of the low Social Security
COLA, a statutory “hold harmless” provision designed to protect seniors, will largely prevent Part B premiums from increasing for about 70 percent of beneficiaries. Among this group, the average 2017 premium will be about $109.00, compared to $104.90 for the past four years.

For the remaining roughly 30 percent of beneficiaries, the standard monthly premium for Medicare Part B will be $134.00 for 2017, a 10 percent increase from the 2016 premium of $121.80. Because of the “hold harmless” provision covering the other 70 percent of beneficiaries, premiums for the remaining 30 percent must cover most of the increase in Medicare costs for 2017 for all beneficiaries. This year, as in the past, the Secretary has exercised her statutory authority to mitigate projected premium increases for these beneficiaries, while continuing to maintain a prudent level of reserves to protect against unexpected costs. The Department of Health and Human Services (HHS) will work with Congress as it explores budget-neutral solutions to challenges created by the “hold harmless” provision.

“Medicare’s top priority is to ensure that beneficiaries have affordable access to the care they need,” said CMS Acting Administrator Andy Slavitt. “We will continue our efforts to improve affordability, access, and quality in Medicare.”

Medicare Part B beneficiaries not subject to the “hold harmless” provision include beneficiaries who do not receive Social Security benefits, those who enroll in Part B for the first time in 2017, those who are directly billed for their Part B premium, those who are dually eligible for Medicaid and have their premium paid by state Medicaid agencies, and those who pay an income-related premium. These groups represent approximately 30 percent of total Part B beneficiaries.

CMS also announced that the annual deductible for all Medicare Part B beneficiaries will be $183 in 2017 (compared to $166 in 2016). Premiums and deductibles for Medicare Advantage and prescription drug plans are already finalized and are unaffected by this announcement.

Since 2007, beneficiaries with higher incomes have paid higher Medicare Part B monthly premiums. These income-related monthly premium rates affect roughly five percent of people with Medicare. The total Medicare Part B premiums for high income beneficiaries for 2017 are shown in the following table:

<table>
<thead>
<tr>
<th>Beneficiaries who file an individual tax return with income:</th>
<th>Beneficiaries who file a joint tax return with income:</th>
<th>Income-related monthly adjustment amount</th>
<th>Total monthly premium amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $85,000</td>
<td>Less than or equal to $170,000</td>
<td>$0.00</td>
<td>$134.00</td>
</tr>
<tr>
<td>Greater than $85,000 and less than or equal to $107,000</td>
<td>Greater than $170,000 and less than or equal to $214,000</td>
<td>53.50</td>
<td>187.50</td>
</tr>
<tr>
<td>Greater than $107,000 and less than or equal to $160,000</td>
<td>Greater than $214,000 and less than or equal to $320,000</td>
<td>133.90</td>
<td>267.90</td>
</tr>
<tr>
<td>Greater than $160,000 and less than or equal to $214,000</td>
<td>Greater than $320,000 and less than or equal to $428,000</td>
<td>214.30</td>
<td>348.30</td>
</tr>
<tr>
<td>Greater than $214,000</td>
<td>Greater than $428,000</td>
<td>294.60</td>
<td>428.60</td>
</tr>
</tbody>
</table>
Premiums for beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate return, are as follows:

<table>
<thead>
<tr>
<th>Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:</th>
<th>Income-related monthly adjustment amount</th>
<th>Total monthly premium amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $85,000</td>
<td>$0.00</td>
<td>$134.00</td>
</tr>
<tr>
<td>Greater than $85,000 and less than or equal to $129,000</td>
<td>214.30</td>
<td>348.30</td>
</tr>
<tr>
<td>Greater than $129,000</td>
<td>294.60</td>
<td>428.60</td>
</tr>
</tbody>
</table>

**Medicare Part A Premiums/Deductibles**

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A inpatient hospital deductible that beneficiaries pay when admitted to the hospital will be $1,316 per benefit period in 2017, an increase of $28 from $1,288 in 2016. The Part A deductible covers beneficiaries’ share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay a coinsurance amount of $329 per day for the 61st through 90th day of hospitalization ($322 in 2016) in a benefit period and $658 per day for lifetime reserve days ($644 in in 2016). For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 of extended care services in a benefit period will be $164.50 in 2017 ($161 in 2016).

Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to receive coverage under Medicare Part A. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be $227 in 2017, a $1 increase from 2016. Uninsured aged and certain individuals with disabilities who have exhausted other entitlement and who have less than 30 quarters of coverage will pay the full premium, which will be $413 a month, a $2 increase from 2016.

**Part A Deductible and Coinsurance Amounts for Calendar Years 2016 and 2017 by Type of Cost Sharing**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital deductible</td>
<td>$1,288</td>
<td>$1,316</td>
</tr>
<tr>
<td>Daily coinsurance for 61st-90th Day</td>
<td>322</td>
<td>329</td>
</tr>
<tr>
<td>Daily coinsurance for lifetime reserve days</td>
<td>644</td>
<td>658</td>
</tr>
<tr>
<td>Skilled Nursing Facility coinsurance</td>
<td>161</td>
<td>164.50</td>
</tr>
</tbody>
</table>

A Healthier Medicare: Focusing on Primary Care, Mental Health, and Diabetes Prevention

CMS BLOG

November 2, 2016
By Andy Slavitt, CMS Acting Administrator (@aslavitt) and
Patrick Conway, MD, MSc, CMS Acting Principal Deputy Administrator and Chief Medical Officer

We’ve discussed a number of times how our country’s health care system historically invested far more in treating sickness than maintaining health. This imbalance contributes to more spending on institutions, hospitals, and nursing homes, rather than keeping people healthy at home and in their communities.

By better valuing primary care, care coordination and prevention, we help people access the services they need to stay well. In addition to keeping people healthy, health care costs are often lower when people have a primary care provider and team of doctors and clinicians overseeing and coordinating their care. And efforts to reduce documentation burden in care management and coordination, tied in with our strategy of physician and clinician engagement, helps keep the focus on patient care that pays for what works and better supports and engages the medical community.

That’s why Medicare and Medicaid, with invaluable support from the CMS Innovation Center, have implemented policies to sharpen their focuses on individuals and their care. Continuing that work, today, Medicare is finalizing policies that improve how it pays for primary care, care coordination, and mental health care, and expanding an exciting CMS Innovation Center payment and service delivery model that aims to prevent diabetes.

Preventing Diabetes & Protecting the Medicare Trust Fund

About 26 percent of people 65 years or older, more than 11 million people, have diabetes. They face higher risks of debilitating complications like heart disease, kidney failure, limb amputations, and blindness. And the treatment of people with diabetes is expensive. It costs Medicare more to support care for those with diabetes than those without diabetes. In total, we estimate that Medicare will spend $42 billion more in the single year of 2016 on fee-for-service, non-dual eligible, over age 65 beneficiaries with diabetes than it would spend if those beneficiaries did not have diabetes -- $20 billion more for Part A, $17 billion more for Part B, and $5 billion more for Part D.

On a per-beneficiary basis, this disparity is just as clear. In 2016 alone, Medicare will spend an estimated $1,500 more on Part D prescription drugs, $3,100 more for hospital and facility services, and $2,700 more in physician and other clinical services for those with diabetes than those without diabetes. That’s approximately $7,300 or 86 percent more per beneficiary, per year for someone with diabetes. This increased spending reflects only Medicare’s share of costs; diabetic beneficiaries likely experience higher out-of-pocket spending as well. Taking care of people with diabetes is important, which is why Medicare provides quality services and support to those with diabetes.
But what if we could slow – or even reduce – the number of people developing diabetes in the first place? What if by focusing on primary care and prevention, we could help people live healthier lives while reducing the costs to the health system and beneficiaries.

The Diabetes Prevention Program model test set out to test this idea. Participants at high risk for developing diabetes were provided strategies to increase their physical activity, control their weight, and decrease their risk of type 2 diabetes. This model led to approximately 5 percent reduction in weight and saved Medicare an estimated $2,650 for each person enrolled in the Diabetes Prevention Program model test over a 15-month period, more than enough to cover the cost of the program.

The Medicare Diabetes Prevention Program (MDPP) expanded model, set to begin in 2018, hopes to make these services available to all eligible Medicare beneficiaries, improving their health and that of the Medicare program both now and in the future. We know that fewer people with diabetes saves patients and Medicare money because they use fewer expensive prescription drugs and have fewer hospital visits. And most importantly, by preventing diabetes, patients and families across the country can avoid suffering from a debilitating disease. That’s why we are expanding the model to make MDPP services available to all eligible Medicare beneficiaries.

The Medicare Diabetes Prevention Program expanded model is the latest successful effort at the Innovation Center to inform the evolution of the Medicare program over time. Other Innovation Center models have tested new ways for doctors and hospitals to work together to support and coordinate care for their patients and better patient safety. Models are eligible for expansion under Section 1115A(c) of the Social Security Act if they meet the following criteria: First, the Secretary of the Department of Health and Human Services determines that such expansion is expected to improve quality of patient care without increasing spending or reduce spending without reducing quality of patient care. Second, the independent CMS Chief Actuary must certify that the expanded model would reduce or not result in any increase in net program spending. Third, the HHS Secretary determines that such expansion will not deny or limit the coverage or provision of benefits Medicare beneficiaries receive. The Medicare Diabetes Prevention Program expanded model meets these criteria.
Refocusing Medicare on Primary Care and Behavioral Health

Also, today, Medicare announced an important set of changes that would improve how Medicare pays for primary care, care coordination, and mental health care. These changes will result in an estimated $140 million in additional funding in 2017 to physicians and practitioners providing these services. Over time, if the clinicians qualified to provide these services were to fully provide these services to all eligible beneficiaries, the increase could be as much as $4 billion or more in additional support for care coordination and patient-centered care.

Clinicians will additionally be able to bill and be paid more appropriately when they spend more time with their patients, serving their patients’ needs outside of the office visit, and better coordinating care. These changes are designed to improve health outcomes. With today’s final primary care payment policies, Medicare continues to move toward a health care system that encourages teams of clinicians to work together and collaborate in order to provide more personalized care for their patients.

Geriatricians, internists, and family physicians provide core services for the Medicare program, including the kinds of care management and patient-centered care that are described by these new codes. Over time, we estimate that the payment increases attributable to these new codes could be as much as 30 and 37 percent respectively to these specialties.

We are also finalizing new coding and payment for care using the Psychiatric Collaborative Care Model that supports mental and behavioral health through a team-based, coordinated approach involving a psychiatric consultant, a behavioral health care manager, and the primary care clinician and which extends beyond the scope of an office visit. This care model has been shown to improve behavioral health outcomes for patients and save money. Payment for care using this model will help address one of the health system’s major challenges -- access for behavioral and mental health care. For anyone who has struggled to gain access to behavioral health care for themselves or a loved one, the importance of these services cannot be overestimated.

Strengthening Primary Care beyond Medicare

As more people age into the Medicare program, we know that access to primary care is an essential tool for their health and wellbeing. We know that effective primary care, care coordination and planning, mental health care, substance use disorder treatment, and care for patients with cognitive and functional impairments can improve outcomes and result in smarter spending. Today’s changes are part of CMS’s broader goal to improve how we pay for care, including through our recently announced Quality Payment Program for Medicare physicians.

We expect to see the impact of these policies far beyond Medicare beneficiaries and hope that they will help strengthen the fabric of primary care throughout the country.


###
III. Low-Income Subsidy Eligible Beneficiary Cost-sharing

As required by section 1860D-14 of the Act, the cost-sharing for low-income subsidy eligible beneficiaries under the basic benefit are indexed either to the increase in average annual drug expenditures of Medicare beneficiaries or to the increase in the Consumer Price Index (CPI).

The maximum copayments below the out-of-pocket threshold for certain low-income full subsidy eligible enrollees and the deductible and the maximum copayments above the out-of-pocket threshold for partial subsidy eligible enrollees are updated using the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary. In addition, the maximum copayments below the out-of-pocket threshold for full benefit dual eligible enrollees with incomes that do not exceed 100% of the Federal poverty line (FPL) are updated by the annual percentage increase in the CPI.

For additional information on the updating of these Part D benefit parameters, please refer to the April 4, 2016 guidance titled “Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter” (2017 Rate Announcement and Call Letter) available on the CMS website at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvSpecRateStats/Announcements-and-Documents.html. Please see the table below for the updated cost-sharing for low-income subsidy eligible beneficiaries in 2017.

### 2017 Maximum LIS Beneficiary Cost-Sharing Table

<table>
<thead>
<tr>
<th>Low-income Subsidy Category</th>
<th>Deductible</th>
<th>Copayment up to Out-of-Pocket Threshold*</th>
<th>Copayment above Out-of-pocket Threshold*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalized Full-Benefit Dual Eligible; or</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Beneficiaries Receiving Home and Community-Based Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-Benefit Dual Eligible ≤ 100% FPL</td>
<td>$0</td>
<td>$1.20 generic, $3.70 brand</td>
<td>$0</td>
</tr>
<tr>
<td>Full-Benefit Dual Eligible &gt; 100% FPL; or</td>
<td>$0</td>
<td>$3.30 generic, $8.25 brand</td>
<td>$0</td>
</tr>
<tr>
<td>Medicare Saving Program Participant (QMB-only, SLMB-only, or QI); or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (but not Medicaid) Recipient; or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicant &lt; 135% FPL with resources ≤ $8,890 ($14,090 if married)**</td>
<td>$82</td>
<td>15%</td>
<td>$3.30 generic, $8.25 brand</td>
</tr>
<tr>
<td>Applicant &lt; 150% FPL with resources between $8,890 - $13,820 ($14,090 - $27,600 if married)**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Out-of-Pocket Threshold is $4,950 for 2017.

** Resource limits displayed include $1,500 per person for burial expenses.
CMS corrective actions cut improper payment rate for inpatient hospital claims by a massive 58.3 percent over the past couple of years

The Centers for Medicare & Medicaid Services (CMS) is dedicated to reducing health care costs while, at the same time, making sure people get access to the right care, when and where they need it. CMS established the Comprehensive Error Rate Testing (CERT) program to calculate the Medicare Fee-for-Service (FFS) program improper payment rate. Due to the successes of corrective actions we put into place to address improper payments for inpatient hospital services, the overall Medicare FFS improper payment rate decreased from 12.1 percent in 2015 to 11.0 percent in 2016. Improper payments for inpatient hospital claims alone dropped a whopping 58.3 percent from 9.2 percent in 2014 to 3.8 percent in 2016. Inpatient hospital claims accounted for $10.45 billion in improper payments during the 2014 report period (July 1, 2012 to June 30, 2013) but was reduced to $4.42 billion during the 2016 report period (July 1, 2014 to June 30, 2015), an improper payment decrease of $6.03 billion.

Two major policies, intensive provider education, and improved oversight contributed to the reduction in improper payments for inpatient hospital claims. First, CMS changed its policy to allow hospitals to bill for Part B (Medical Insurance) services given during a hospital inpatient stay when an inpatient admission is found not to be reasonable and necessary. Second, CMS clarified policy for when an inpatient admission is generally appropriate for payment under Medicare Part A (Hospital Insurance) by establishing and modifying the “Two-Midnight rule.” The Two-Midnight rule applied to admissions beginning on or after October 1, 2013, and established benchmark criteria that should be used when determining whether a short stay hospital admission is payable under Medicare Part A. The Two-Midnight rule stated that inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.

Along with these policy changes, CMS put into place a comprehensive educational campaign to help providers comply with the regulations. After a limited number of “probe” audits of each provider’s short stay claims for Part A payment, Medicare Administrative Contractors (MACs) sent letters to the providers detailing the results of the probe audit and offered one-on-one education to further discuss the errors and encourage a change in future billing behavior. Providers with moderate or major error findings were engaged in up to three additional rounds of review and education to encourage greater accuracy with future claim submissions.

CMS is building on these corrective action successes by exploring opportunities to implement prior authorization and pre-claim review programs. We plan to continue monitoring those services whose payment vulnerabilities drive the improper payment rate, like home health and inpatient rehabilitation claims, to more effectively target our provider education and medical review efforts.

While CMS is pleased with the reductions we’ve already seen in the improper payment rate, we remain committed to collaborating across CMS to address potential vulnerabilities identified through our improper payment measurement programs and continuing to strengthen our program integrity efforts.

Medicare Finalizes Substantial Improvements that Focus on Primary Care, Mental Health, and Diabetes Prevention

On November 2, CMS finalized the 2017 Physician Fee Schedule final rule that recognizes the importance of primary care by improving payment for chronic care management and behavioral health. The rule also finalizes many of the policies to expand the Diabetes Prevention Program model test to eligible Medicare beneficiaries, the Medicare Diabetes Prevention Program (MDPP) expanded model, starting January 1, 2018.
The annual Physician Fee Schedule updates payment policies, payment rates, and quality provisions for services provided in CY 2017. In addition to physicians, a variety of practitioners and entities are paid under the physician fee schedule. Additional policies finalized in the 2017 payment rule include:

- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning

The 2017 payment rule will also:

- Finalize a data collection strategy for global services with significantly reduced burden for practitioners compared to the proposal
- Finalize a change that will more accurately reflect local costs and significantly increase payments to practitioners in Puerto Rico
- Enhance program integrity and data transparency in the Medicare Advantage program.

For More Information:

- Final Rule
- PFS Fact Sheet
- MDPP Fact Sheet
- Blog

See full text of this excerpted CMS press release

###

CMS publishes proposed rule on Fire Safety Requirements for Applicable Dialysis Facilities

Today, the Centers for Medicare & Medicaid Services (CMS) announced a proposed rule to update Medicare fire protection guidelines for certain dialysis facilities to ensure that patients are protected from fire while receiving treatment in those facilities. CMS strives to promote health and safety for all patients, family, and staff in every provider and supplier setting, and fire safety requirements are an important part of this effort.

The new proposed guidelines apply to all dialysis facilities that do not provide one or more exits at grade level from the treatment area level. CMS previously updated the requirements to include dialysis facilities located adjacent to industrial high hazard occupancies; however, as dialysis facilities are not permitted to be located in such areas, the requirement specific to such geographically located facilities will be removed.

This rule adopts, for certain dialysis facilities, updated provisions of the National Fire Protection Association’s (NFPA) 2012 edition of the Life Safety Code (LSC), as well as provisions of the NFPA’s 2012 edition of the Health Care Facilities Code in order to bring CMS’s requirements more up to date with today’s fire safety standards. The LSC is a compilation of fire safety requirements for new and existing buildings, and is updated every three years.

The proposed rule addresses construction, protection, and operational features of dialysis facilities to provide safety for Medicare beneficiaries from fire and smoke. Some of the main requirements laid out in this proposed rule include:

- Doors to hazardous areas must be self-closing or must close automatically.
- Alcohol based hand rub dispensers now may be placed in corridors to allow for easier access.
- A fire watch or building evacuation is required if the sprinkler system is out of service for more than 10 hours.
Currently, CMS is using the 2000 edition of the LSC to survey dialysis facilities for health and safety compliance. With this proposed rule, CMS is adopting provisions of the 2012 edition of the LSC and provisions of the 2012 edition of the Health Care Facilities Code, to bring CMS’s requirements more up to date, and align dialysis facility fire safety requirements with the codes CMS uses to survey other healthcare facilities.

###

**A Message About Medicare Premiums to Medicare Beneficiaries**
The Medicare Part B premium amount for 2017 was not available in time to include with this bill. As a result, you are being billed the current 2016 premium rate for the months of January and February 2017. Your next bill will reflect the new rate for 2017 and any difference in the amount due for January and February 2017.

**Payment Reminders**
- **Medicare premium payments are due by the 25th of the month.** Payments received after the 25th will be reflected on your next bill.
- Please write your Medicare number on your check or money order. Look on your red, white and blue Medicare card for your Medicare number.

For questions about your Notice of Medicare Premium Payment Due, please call Social Security at 1-800-772-1213 or contact your local Social Security Office. TTY users should call 1-800-325-0778. If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**Pay Your Bill Online**
Many banks now let you pay your bills online. If your bank offers an online bill payment service, you can use it to pay your Medicare premiums electronically. Contact your bank for information on how to sign up for their Online Bill Pay Service and pay your premiums directly to CMS from a bank account. For more information about paying your bill online, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

The information is printed in Spanish on the back
Un mensaje sobre las primas de Medicare
La cantidad de la prima de la Parte B de Medicare para 2017 no estaba disponible para incluirla en esta factura. Por esta razón, se le está cobrando la prima actual de 2016 para el mes de enero y febrero del 2017. Su próxima factura reflejará la nueva cantidad para el 2017 y cualquier diferencia a pagar en la prima para el mes de enero y febrero del 2017.

Aviso sobre los pagos
• Los pagos de las primas de Medicare se vencen el día 25 de cada mes. Los pagos que se reciban después de esta fecha, se reflejarán en la próxima factura.

• Escriba su número de cuenta de Medicare en su cheque o giro postal. Para conseguir el número de cuenta, mire en su tarjeta roja, blanca y azul de Medicare.

Si tiene preguntas sobre su Aviso de Pago de la Prima de Medicare, llame al 1-800-772-1213 o comuníquese con su oficina local del Seguro Social. Los usuarios de TTY deberán llamar al 1-800-325-0778. Si tiene preguntas sobre Medicare, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deberán llamar al 1-877-486-2048.

Pague su Cuenta en Línea
Muchos bancos ahora le permiten pagar sus facturas en línea. Si su banco ofrece un servicio de pago en línea, usted puede utilizarlo para pagar sus primas de Medicare electrónicamente. Comuníquese con su banco para obtener información sobre cómo registrarse en el Servicio de Pagos en Línea y pagar sus primas directamente a CMS usando una cuenta bancaria. Para obtener más información sobre cómo pagar su factura en línea, visite Medicare.gov o llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

La información en inglés está impresa al dorso
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CMS Hospital Value-Based Purchasing Program Results for Fiscal Year 2017

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

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

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

• Clinical Care
  o Outcomes (25 percent)
  o Process (5 percent)
• Patient and Caregiver Centered Experience of Care/Care Coordination (25 percent)
• Safety (20 percent)
• Efficiency and Cost Reduction (25 percent)
We have posted the Hospital VBP incentive payment adjustment factors for FY 2017 in Table 16B, available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

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

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

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

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

**Computing the VBP Score**

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

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

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

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

**New Program Requirements for FY 2018**

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

- We are removing two measures from the Clinical Care – Process subdomain (the AMI-7a and IMM-2 measures) and are moving the remaining measure (PC-01) to the Safety domain.
- We are adding a three-item Care Transition dimension, which is part of the Hospital Consumer Assessment of Hospital Providers and Systems (HCAHPS) survey, to the Patient and Caregiver Centered Experience of Care/Care Coordination domain.
- In the Calendar Year (CY) 2017 Outpatient Prospective Payment System (OPPS) proposed rule, we proposed to remove the Pain Management dimension, which is derived from the HCAHPS survey, from the Patient and Caregiver Centered Experience of Care/Care Coordination domain beginning with the FY 2018 VBP program year. We intend to address the proposal and respond to any comments submitted in the CY 2017 OPPS final rule anticipated for release in November 2016.
The FY 2018 Hospital VBP Program will include four equally-weighted domains:

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

**Moving Forward**

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

**Additional Information**

For more information on the Hospital VBP Program, please visit the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html and the QualityNet website at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937.

###

**Updated Medicare and Medicaid Drug Spending Dashboard**

November 14

By Andy Slavitt, Acting CMS Administrator, Niall Brennan, CMS Chief Data Officer, Tim Gronniger, CMS Deputy Chief of Staff

The increased costs of prescription drugs are one of the most critical items for American families. The development of high-value prescription drugs has improved the health and wellbeing of millions of Medicare and Medicaid beneficiaries. The continued investment in innovation is critical to unlock the treatments for many diseases such as cancer and Alzheimer’s, and help us better manage our chronic conditions like diabetes, heart disease and depression, providing significant benefits to patients across the country.

However, in order to have the maximum impact on these innovations, medications must also be affordable and accessible. In the last several months, we have heard about rapidly increasing prices for Epi-Pen, the rising lockstep cost of insulin medications, and the practice of some companies hiking prices by combining two cheaper products into one, higher-priced drug.

In order to provide a better sense of the frequency and pervasiveness of these increases, last year CMS published a new interactive tool that tracks the price of drugs purchased for Medicare beneficiaries. This tool allows the public to view drugs in Medicare Part B and D with high spending on a per user basis, high spending for the program overall, and those with high unit cost increases in recent years. Individual entries contain helpful graphs on trends for specific drugs over the last five years, as we see below for a drug that helps to control high blood sugar.
This year, we are not only updating that tool with more current information, but are adding two important new pieces of information. First, we are adding information on drugs purchased for Medicaid beneficiaries, which totals another $57 billion in spending in 2015. Second, in an effort to provide more precise information, this year we are adding some high level information on rebates provided by drug manufacturers to offset some of the high drug costs in Medicare.

Overall, there is significant growth in spending on prescription drugs, representing a significant burden. In 2015, total prescription drug costs were estimated to have been $457 billion, or 16.7 percent of personal health care spending. This is up from $367 billion, or 15.4 percent of personal health care spending in 2012. With annual growth expected to average 6.7 percent annually through 2025, we can expect increasing costs to continue to put pressure on families and programs that cover prescription drugs.
Because Medicare and Medicaid beneficiaries often live on low- and fixed-incomes, the high and rising cost of certain drugs takes a significant toll on them. And prescription drug costs don’t only hit American seniors, people with disabilities, and low-income families; they also have a significant impact on taxpayers.

- Total costs for Medicare Part D above the catastrophic limit increased by 85 percent to a total of $51 billion from 2013 to 2015, before accounting for rebates. Medicare pays 80 percent of the costs above the catastrophic limit.

- An estimated 25 percent of the increase in Medicaid spending on prescription drugs between 2013 and 2014 was due to increased utilization, while 75 percent was due to increases in price.

The updated online dashboard tool presents information for three categories of Medicaid prescription drugs: drugs with high spending for the program overall, those with high spending on a per-prescription fill basis, and those with high unit cost increases in recent years. The dashboard provides trend analyses as well as additional detailed information on each drug, such as drug spending, number of prescription fills, brand and generic name, uses, and the name of the manufacturer.

For Medicare, this dashboard presents 80 drugs using 2015 data that met the criteria described below: 40 drugs provided through the Medicare Prescription Drug Program under Part D and 40 drugs administered by physicians and other professionals in the Medicare fee-for-service program under Part B. Products have been selected from each respective program based on three criteria: the top 15 drugs in total program spending; 15 drugs with both very high per-user spending and significant program spending; and 10 drugs with very high unit cost increases. For all drugs included on the list, the dashboard displays relevant spending, utilization, and trend data and also includes consumer-friendly information on the drug product descriptions, manufacturer(s), and clinical indications.

For both Medicare and Medicaid, the dashboard also provides information on the availability of Evidence-based Practice Center (EPC) reports from the Agency for Healthcare Research and Quality when available for a drug.

We encourage you to explore this information, which adds to the growing amount of data available. There are a number of highlights and some examples below.

**Key Findings – Medicaid**

- **Highest total spending on a single drug** changed in 2015 with Harvoni, the brand name Hepatitis C virus treatment, overtaking Abilify (a brand name treatment for schizophrenia, depression, and other illnesses), which was the drug with the highest total spending in Medicaid from 2011 to 2014.

**Trends in Medicaid Total Spending for the Top 5 Drugs**
• **Joint impact to Medicare and Medicaid.** The top two Medicare Part D drugs — Harvoni, the highly-effective brand name Hepatitis C therapy; and the diabetes management treatment and insulin pen, Lantus — also made it into the top five Medicaid drugs in terms of total spending. Each were associated with more than $1 billion in Medicaid spending.

• **Impact of unit increases.** Ativan, a brand name drug to treat anxiety, had an average unit cost increase of 1,264 percent between 2014 and 2015. There were five other drugs that had unit cost increases of more than 300 percent. In total, Medicaid spending on these 20 drugs with unit cost increases more than doubled from $146 million in 2014 to $486 million in 2015.

• Among Medicaid drugs with the highest cost per prescription fill, Advate, the brand name hemophilia treatment that prevents deadly bleeding episodes in adults and children, had an average cost per fill of $20,828 and was associated with total program spending of $354 million.

• **Dashboard drug lists may not include drugs covered in the news today.** EpiPen, for example, does not appear in the top 20 Medicaid drug price increases or spending because because its large price increases occurred prior to this year. However, CMS data shows that Medicare and Medicaid spending on EpiPens rose by more than 500 percent from 2011 to 2015.

Of the 20 drugs with the highest per-unit cost increases in Medicaid, nine were generic drugs. Those products had increases in price ranging from 140 percent to nearly 500 percent between 2014 and 2015.

**Key Findings – Medicare**
- The **five Medicare Part D drugs with highest total drug spending** each accounted for more than $2 billion in gross spending in Part D in 2015. The five drugs with the highest total Medicare Part B spending in 2015 are the same as 2014 and combined they totaled more than $7 billion in spending.

  **Trends in Medicare Part D Total Spending for the Top 5 Drugs**

<table>
<thead>
<tr>
<th>Drug</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiriva</td>
<td>$2.0</td>
<td>$2.0</td>
</tr>
<tr>
<td>Advair Diskus</td>
<td>$2.0</td>
<td>$2.0</td>
</tr>
<tr>
<td>Crestor</td>
<td>$3.0</td>
<td>$4.0</td>
</tr>
<tr>
<td>Lantus/Lantus Solostar</td>
<td>$4.0</td>
<td>$8.0</td>
</tr>
<tr>
<td>Harvoni</td>
<td>$1.0</td>
<td>$8.0</td>
</tr>
</tbody>
</table>

- Among the **Part D drugs with the highest unit cost**, the chemotherapy agent that treats leukemia and other cancers, Gleevec, had a per user cost of $81,152 and was associated with total program spending of $1.2 billion.
- The brand name drug Glumetza that manages high blood sugar had an average unit cost increase of 381 percent in Part D between 2014 and 2015. There were three other drugs that had **increases of more than 200 percent**.
- Among Part B drugs, the brand name treatment for multiple sclerosis and Crohn’s disease Tysabri had a per user cost of $39,767 and **total program spending** of $288.8 million.
- The generic chemotherapy drug Mitomycin that treats stomach, pancreatic, and other cancers, had an **average unit cost increase** of 163 percent in Part B between 2014 and 2015, and there were six products that had unit cost increases of more than 20 percent.

  **Rebates in the Medicare Program**

  These data do not include rebate information that Medicare may receive from pharmaceutical manufacturers because federal law restricts the release of this information. But, for the first time, we are able to provide an aggregated summary of Medicare Part D manufacturer rebate information for calendar year 2014 for several broad categories of brand name drugs [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs/2014_PartD_Rebates.html].
In total, more than $16 billion in manufacturer rebates for brand name drugs were collected by Medicare Part D plans in 2014 for an average rebate of 17.5 percent. Among the Medicare Part D brand name drugs listed in the 2014 dashboard, the average manufacturer rebate was 17.8 percent. Twenty-two of these drugs accounted for a total of $6.6 billion in rebates. As reported by the HHS Office of Inspector General, it has been found that drug rebates in the Medicare Part D program are generally lower compared to other payors. Part of the reason for this is that Medicare cannot harness its full purchasing power to negotiate for rebates across all Part D plans. We believe releasing this information, even at this higher level, helps to shed new light on the relationship between drug pricing and overall program costs.

Concluding Point

We know that millions of Americans have come to rely on these prescription drugs to manage their chronic conditions or to treat serious illnesses. Maintaining access to those medications is the reason we believe informed dialogue on how to manage costs and cost increases are so important.

As administrators for the Medicare and Medicaid program, our most important goal is to make sure that beneficiaries have access to high-value, innovative medicines that improve their lives. But because costs necessarily get passed on to beneficiaries and taxpayers through higher premiums, coinsurance, and taxes, we also have a responsibility to ensure that access to those medicines remains affordable. We hope by providing a better view into our spending on prescription drugs, this understanding can help policy makers, manufacturers, purchasers, and consumers to work together to better the health of all Americans.

###

CMS Awards Contracts for the DMEPOS Competitive Bidding Program Round 1 2017

OVERVIEW
The Centers for Medicare & Medicaid Services (CMS) today announced the Round 1 2017 contract suppliers for Medicare’s Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. This program has been in effect since 2011 and is an essential tool to help Medicare set appropriate payment rates for DMEPOS items, save money for beneficiaries and taxpayers, while ensuring access to quality items.

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

Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas (CBAs). Since implementation of the DMEPOS Competitive Bidding Program on January 1, 2011, CMS has saved approximately $220 million per year in the nine Round 1 metropolitan statistical areas (MSAs) due to competitive bidding and other CMS fraud, waste, and abuse initiatives. Health monitoring data indicate that the program implementation is going smoothly with few inquiries or complaints and no negative beneficiary health outcomes. The Round 1 Recompete contract period expires on December 31, 2016, and Round 1 2017 contracts will become effective on January 1, 2017, through December 31, 2018.

BACKGROUND
The Medicare DMEPOS Competitive Bidding Program was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“Medicare Modernization Act” or “MMA”) after the conclusion of
successful demonstration projects. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 Metropolitan Statistical Areas (MSAs) in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS successfully conducted the supplier competition again in nine areas in 2009, referring to it as the Round 1 Rebid.

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

Competitive bidding contracts and pricing have been in place in Round 1 areas since January 1, 2011, with the current Round 1 Recompete contracts and prices being in place since January 1, 2014. Round 1 2017 will be implemented on January 1, 2017.

**CONTRACT AWARD PROCESS**

For Round 1 2017, CMS has executed 182 DMEPOS competitive bidding program contracts (92 percent of contracts offered). The Round 1 2017 contract suppliers have 534 locations to serve Medicare beneficiaries in these CBAs. Contract suppliers are required to meet CMS’ quality standards, meet applicable state licensure requirements, and be accredited by a CMS approved independent accreditation organization.

The DMEPOS Competitive Bidding Program’s bid evaluation process ensures that there will be a sufficient number of suppliers, including small suppliers, to meet the needs of the beneficiaries living in the CBAs. In fact, 92 percent of contract suppliers are already established in the CBA, the product category, or both. CMS was required to include small supplier protections for the program, and instituted a 30 percent small supplier target in each CBA. For Round 1 2017, 93 percent of small suppliers, those with gross revenues of $3.5 million or less as defined for the program, accepted their contract offer.

Bidders that were not offered contracts were notified of the reason(s) why they did not qualify for the program. All suppliers that did not win contracts were provided a targeted period to ask questions or express concerns about the reason(s) why they were not awarded a contract. Suppliers that are not contract suppliers for this round of the Program may bid in future rounds, unless they are precluded from participation in the program.

Contract supplier names and locations for each product category in each CBA can be found in the Supplier Directory at [www.medicare.gov/supplier](http://www.medicare.gov/supplier).

**REAL-TIME MONITORING**

Importantly, the program has maintained beneficiary access to quality products from accredited suppliers in all CBAs. Extensive real-time monitoring data have shown successful implementation with very few beneficiary complaints and no negative impact on beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency room visits compared to non-CBAs. In addition to real-time claims monitoring, CMS also requested feedback from beneficiaries through consumer satisfaction surveys conducted before and after the rollout of the program. CMS provides local, on-the-ground presence in each CBA through the CMS regional offices, local liaisons, and a Competitive Acquisition Ombudsman who closely monitors and responds to inquiries and complaints about the application of the program from beneficiaries who use items of DMEPOS under the program, contract suppliers who provide these items, and other stakeholders. There is also a formal complaint process for beneficiaries, caregivers, providers, and suppliers to use for reporting concerns about contract suppliers or other competitive bidding implementation issues. In addition, contract suppliers are responsible for
submitting reports identifying the brands of products they furnish, which are used to inform beneficiaries, caregivers, and referral agents. CMS will continue to employ the same aggressive program monitoring for future rounds.

**ROUND 1 2017 PRODUCT CATEGORIES AND AREAS**

The Round 1 2017 product categories are:

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

For a list of specific items in each product category, or for a list of the areas included in Round 1 2017, visit the Competitive Bidding Implementation Contractor website, [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com).

**ROUND 1 2017 TIMELINE OF EVENTS**

**November 1, 2016**  CMS announces the Medicare contract suppliers for Round 1 2017; intensifies supplier, referral agent, and beneficiary education program

**January 1, 2017**  Implementation of Medicare DMEPOS Competitive Bidding Program Round 1 2017 contracts and prices

**ADDITIONAL INFORMATION**

For additional information, visit the Medicare DMEPOS Competitive Bidding Program homepage located on the CMS website.

###

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

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

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

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

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

**Payment Policy Provisions**

**Rebasings the 60-day Episode Rate**

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

In this final rule, CMS would complete the final year of the four-year phase-in of the rebasing adjustments to the HH PPS payment rates. As finalized in the CY 2014 final rule, the CY 2017 rebasing adjustment to the national, standardized 60-day payment rate is -$80.95. The overall impact due to the rebasing adjustments is estimated to be a 2.3 percent decrease in HH PPS payments for CY 2017. As noted above and further below, this is offset by the home health payment update percentage, which would increase overall HH PPS payments in CY 2017 by 2.5 percent.

**Updates to Reflect Case-Mix Growth**

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

**Negative Pressure Wound Therapy (NPWT)**

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

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

Other Updates

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

Home Health Quality Reporting Program (HH QRP) Update

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

Following opportunities for proposed rule public comment, as well as measure development related technical expert review and public comment and the review by the measures application partnership process, in this final rule and beginning with the CY 2018 payment determination, CMS adopted four measures to meet the requirements of the IMPACT Act. Three of these measures are calculated using Medicare claims. The Total Medicare Spending per Beneficiary - Post Acute Care Home Health Quality Reporting Program (MSPB-PAC HH QRP) measure does not require additional data submission. The fourth measure is assessment-based and is calculated using Outcome and Assessment Information Set (OASIS) data. The various measures are as follows:

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

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

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

CMS’s measure development and maintenance contractor convened a Technical Expert Panel (TEP) on August 21, 2015, to review and advise on the reevaluation results. Information regarding the TEP’s feedback is available at:
As a result of the comprehensive reevaluation, CMS identified 28 HHQI measures that were either “topped out” and/or determined to be of limited clinical and quality improvement value by TEP members. Therefore, these measures will no longer be included in the HHQI. A list of these measures, along with our reasons for no longer including them in the HHQI, can be found at the following link:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html. In addition, based on the results of the comprehensive reevaluation and the TEP input, we finalized to remove six process measures from the HH QRP, beginning with the CY 2018 payment determination, because they are “topped out” and therefore no longer have sufficient variability to distinguish between providers in public reporting.

### Home Health Value-Based Purchasing Model

In the CY 2016 Home Health Prospective Payment System final rule, CMS finalized its proposal to implement the Home Health Value-Based Purchasing (HHVBP) Model in nine states representing each geographic area in the nation. For all Medicare-certified home health agencies (HHAs) that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, payment adjustments will be based on each HHA’s total performance score on a set of measures already reported via OASIS and HHCAHPS for all patients serviced by the HHA, or determined by claims data, plus three new measures where points are achieved for reporting data.

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

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

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

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

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

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

###
Medicare Learning Network Provider News

News & Announcements

- Proposed Rule on Fire Safety Requirements for Applicable Dialysis Facilities
- IMPACT Act Cross-Setting Quality Measure on Pressure Ulcers: Comments due November 17
- 2017 PQRS Results: Submit an Informal Review by November 30
- Value Modifier: Informal Review Request Period Open through November 30
- IRF-PAI and LTCH Provider Reports Retention Change: Take Action by December 1
- Open Payments: Physicians and Teaching Hospitals Review Public Data by December 31
- Quality Payment Program Presentations Available
- New Guide Helps Nursing Homes Tackle Antimicrobial Stewardship
- Raising Awareness of Diabetes in November
- Updates to Dialysis Facility Compare: Patient Experience Ratings Available
- Hospital Value-Based Purchasing Program Results for FY 2017
- DMEPOS Competitive Bidding Program: CMS Awards Contracts for Round 1 2017
- 2017 PQRS Results: Submit an Informal Review by November 30
- IRF and LTCH Quality Reporting Program: NHSN Rebaseline Guidance
- Recovery Audit Contractor Awards
- Antipsychotic Drug use in Nursing Homes: Trend Update
- November is Home Care and Hospice Month
- CMS and Indian Health Service Expand Collaboration to Improve Health Care in Hospitals
- CMS to Release a Comparative Billing Report on Knee Orthoses in January
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- Compliance Program Basics
- Chiropractic Services: High Part B Improper Payment Rate
- False Claims Act

Claims, Pricers & Codes

- Re-release of V34 ICD-10 MS-DRG Grouper, Definitions Manual, and Errata Available
- Billing for Influenza: New CPT Code 90674
- Sunsetting of Section 1011: Emergency Health Services Furnished to Undocumented Aliens
- LTCH: Clarification of Immediately Preceding Hospitals for Exclusion from Site Neutral Payment Rate

Upcoming Events

- 2016 Hospital Appeals Settlement Call — November 16
- IRF and LTCH: Transition to NHSN Rebaseline Webinar — November 16
- Medicare Diabetes Prevention Program Model Expansion Call — November 30
- IRF and LTCH Quality Measure Report Call — December 1
- National Partnership to Improve Dementia Care and QAPI Call — December 6
- CMS 2016 Quality Conference — December 13-15
- Medicare Diabetes Prevention Program Model Expansion Call — November 30
- IRF and LTCH Quality Measure Report Call — December 1
- 2016 Hospital Appeals Settlement Update Call — December 12
CMS Finalizes Hospital OPPS Changes to Better Support Hospitals and Physicians and Improve Patient Care

On November 1, CMS finalized updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for CY 2017. CMS is also adding new quality measures to the Hospital Outpatient Quality Reporting Program and the ASC Quality Reporting Program that are focused on improving patient outcomes and experience of care. CMS estimates that the updates in the final rule would increase OPPS payments by 1.7 percent and ASC rates by 1.9 percent in 2017.

Included in the rule:

- Addressing physicians’ concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology

For More Information:

- Final Rule
- Fact Sheet

See the full text of this excerpted CMS Press Release (issued November 1).

Home Health Agencies: Final Payment Changes

On October 31, CMS announced final changes to the Medicare Home Health (HH) Prospective Payment System (PPS) for CY 2017. In the final rule (CMS-1648-F), CMS estimates that Medicare payments to home health agencies in CY 2017 would be reduced by 0.7 percent, or $130 million based on the finalized policies.
Payment policy provisions:

- Rebasing the 60-day episode rate
- Updates to reflect case-mix growth
- Negative Pressure Wound Therapy
- Change in methodology and the fixed-dollar loss ratio used to calculate outlier payments
- Other updates

The final rule also includes:

- Home Health Quality Reporting Program
- Home Health Value-Based Purchasing Model

For More Information:

- Final Rule
- HH PPS website
- HH Value-Based Purchasing Model webpage

See the full text of this excerpted CMS fact sheet (issued October 31).

###

**ESRD PPS: Policies and Payment Rates for End-Stage Renal Disease**

On October 28, CMS issued a final rule (CMS 1651-F) that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2017. This rule also:

- Finalizes new quality measures to improve the quality of care by dialysis facilities treating patients with ESRD
- Implements the Trade Preferences Extension Act of 2015 provisions regarding the coverage and payment of renal dialysis services furnished by ESRD facilities to individuals with acute kidney injury
- Makes changes to the ESRD Quality Incentive Program (QIP), including Payment Years (PYs) 2019 and 2020
- Makes changes to the scoring methodology for the ESRD QIP for PY 2019 and added one new measure
- Addresses issues related to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and the DMEPOS Competitive Bidding Program

The finalized CY 2017 ESRD PPS base rate is $231.55. CMS projects that the updates for CY 2017 will increase the total payments to all ESRD facilities by 0.73 percent compared with CY 2016. For hospital-based ESRD facilities, CMS projects an increase in total payments of 0.9 percent, while for freestanding facilities, the projected increase in total payments is 0.7 percent. Aggregate ESRD PPS expenditures are projected to increase by approximately $80 million from CY 2016 to CY 2017.

Changes to the ESRD PPS:

- Update to the base rate
- Annual update to the wage index and wage index floor
- Update to the outlier policy
- Home and self-dialysis training add-on payment adjustment

Changes to the DMEPOS Competitive Bidding Program:

- Bid surety bond
- State licensure
- Appeals process for breach of contract actions
- Bid limits
- Changes for similar items with different features

For More Information:

- Final Rule
See the full text of this excerpted CMS fact sheet

###
Our Report to the President on Mental Health and Substance Use Disorder Parity

October 27, 2016

By: Cecilia Muñoz, Director, White House Domestic Policy Council and Thomas E. Perez, Secretary of Labor

Summary:
Federal Parity Task Force Takes Steps to Strengthen Insurance Coverage for Mental Health and Substance Use Disorders

From the national opioid epidemic to disturbing rates of suicide, we see the consequences every day of untreated mental health and substance use disorders. Access to effective mental health and substance use disorder services can mean the difference between graduating from school and falling behind; between keeping a good job and becoming involved with the criminal justice system; between living a full life in recovery and dying by overdose or suicide. But if those services are needed, will your health insurance cover them in the same way it covers other medical treatment?

Six months ago, President Obama established a Federal Task Force to help make sure the answer is yes.

The Mental Health and Substance Use Disorder Parity Task Force was led by the Domestic Policy Council and consisted of the Departments of Labor, the Treasury, Defense, Justice, Health and Human Services, and Veterans Affairs, as well as the Office of Personnel Management and the Office of National Drug Control Policy. Our Task Force met with consumers, providers, employers, health plans, and State regulators, and read more than 1,100 public comments.

Today, we are presenting the President our final report, which includes a series of new actions and recommendations to ensure that insurance coverage for mental health and substance use disorder services is comparable to—or at parity with—general medical care.

Parity laws and regulations aim to eliminate restrictions on mental health and substance use disorder coverage – like annual visit limits, higher copayments, separate deductibles for mental health and substance use disorder services, and rules on how care is managed (such as pre-authorizations or medical necessity reviews) – if comparable restrictions are not placed on medical and surgical benefits. Comprehensive insurance coverage that meets parity requirements can provide access to treatment and services, which in turn can reduce the difficulties faced by people with mental health and substance use disorders, help their loved ones, and increase their independence.

However, parity is only meaningful if health plans are implementing it well, consumers and providers understand how it works, and the government provides clear guidance and appropriate oversight.

During its tenure, Task Force agencies produced a user-friendly “Know Your Rights” brochure to increase knowledge about parity; released guidance outlining plans’ obligations for disclosing information to assess their compliance with parity; and issued a best practices report based on a series of interviews with State regulators on parity implementation and enforcement.

In conjunction with the final report, the Task Force announced an additional series of immediate action steps to advance parity. Examples of these steps include:

- $9.3 million to States to help implement parity protections. Stakeholders told the Task Force that States need support and resources to ensure issuer compliance with parity.
- A beta version of a new parity Web site to help consumers find the appropriate Federal or State agency to assist with their parity complaints, appeals, and other actions. The Task Force received many comments about the challenges consumers face in identifying the appropriate agency that regulates their insurance coverage.
- A Consumer Guide to Disclosure Rights to help consumers and providers understand what type of information to ask for when inquiring about a plan’s compliance with parity. The Guide includes 11 scenarios, each with specific suggestions for information consumers have a right to that can help, as well as timing requirements for plans and issuers providing these documents.
• Guidance on the application of parity to opioid use disorder treatment that responds to concerns raised by consumers about insurance barriers to timely treatment.

Examples of the longer-term recommendations included in the Task Force final report include:

• Increase Federal agencies’ capacity to audit health plans for parity compliance. Stakeholders have consistently called for enhancing audit capacity to improve oversight and enforcement of parity protections. The Task Force concurred with this view and recommends increasing resources for this purpose.

• Allow the Department of Labor to assess civil monetary penalties for parity violations. Commenters called for stronger enforcement tools and the Task Force recommends providing the Department of Labor with this increased authority.

• Work with the National Association of Insurance Commissioners and States to develop a standardized template that States could use to help assess parity compliance. Commenters noted the challenge of State variation in approaches to parity oversight.

• Ensure timely implementation of new Medicaid and TRICARE parity rules.

These and the other actions and recommendations in the Task Force report build on the ongoing work of the Administration to ensure that people with mental health and substance use disorders receive the care they need.

For example, the Affordable Care Act ended insurance company discrimination based on pre-existing conditions, including mental health and substance use disorders; required coverage of mental health and substance use disorder services in the individual and small group insurance markets; ensured that recommended preventive screenings, including for depression and alcohol misuse, are available with no co-pays; and, expanded Medicaid to millions of additional Americans, significantly improving coverage for mental health care and substance use disorder treatment.

The work of the Task Force provides a road map for moving forward so that our country will continue to make significant progress in expanding mental health and substance use disorder coverage for millions of Americans.

The final report is available here: [http://www.hhs.gov/parity](http://www.hhs.gov/parity)

###

**CMS and Indian Health Service expand collaboration to improve health care in hospitals**

*Efforts benefit 2.2 million American Indians and Alaska Natives eligible for IHS services*

The Centers for Medicare & Medicaid Services (CMS) now includes Indian Health Service (IHS) Hospitals in the nationwide Hospital Improvement and Innovation Networks (HIINs) contract for public and private sector hospitals to reduce adverse events by 20 percent and hospital readmissions by 12 percent. This commitment to American Indian and Alaska Native (AI/AN) health care is part of ongoing CMS and IHS work to address issues in hospitals before they can affect patients.

CMS recently awarded $347 million to 16 national, regional, or state hospital associations and health system organizations to serve as HIINs. This announcement follows a recent (October 4, 2016) declaration of a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) to support best health care practices and other operational improvements in IHS federal government operated hospitals. Both programs work in coordination and support of the Department of Health and Human Service (HHS) Executive Council on Quality Care. The IHS hospital system includes 25 Medicare certified hospitals that will receive assistance from the Premier HIIN to reduce preventable hospital-acquired conditions and readmissions.

The HIIN contracts awarded build upon collective momentum of the Hospital Engagement Networks (HENs) and QIN-QIOs to reduce adverse events and readmissions. IHS previously participated in the CMS-funded HENs. The HIINs represent the next phase of the Partnership for Patients initiative (PIP), one of the first models established by the CMS Innovation Center in 2011 to be tested under the authority of the Social Security Act, and which aims to
reduce program expenditures while preserving or enhancing quality of care. Since the PfP launch, and in collaboration with the HENs and other public and private stakeholders, many U.S. hospitals have delivered unprecedented national reductions in patient harm. For example, from 2010–2014, 17 percent of hospital-acquired conditions (HACs) such as adverse drug events, healthcare-associated infections, and pressure ulcers have been prevented in hospital patients. Reducing these HACs has saved an estimated 87,000 lives and nearly $20 billion in health care costs.

“We look forward to continuing the next phase of working collaboratively in each Medicare-certified IHS hospital on harm reduction and system level improvement,” said Patrick Conway, M.D. CMS’ acting principal deputy administrator and chief medical officer. “This offers a great opportunity to create significant positive changes in health outcomes of American Indian and Alaska Native communities serviced by these hospitals.”

“We are so pleased to continue collaborating with CMS to build strong hospitals in which patients are protected from getting injured and receive high quality care so they can heal without complication,” said IHS principal deputy director Mary L. Smith. “IHS participation in the Network will benefit our American Indian and Alaska Native patients because this further strengthens IHS ongoing efforts to provide the highest quality care.”

Through 2019, HIINs will work to achieve a 20 percent decrease in overall patient harm and a 12 percent reduction in 30-day hospital readmissions as a population-based measure (readmissions per 1,000 people) from the 2014 baseline. Health equity for people with Medicare benefits will be central to the HIIN efforts.

###
Join us for the CMS National Training Program Monthly Partner Update Webinar
December 6, 2016  2:30 – 3:30 pm ET

This webinar will feature presentations on:

- Chronic Care Management System
- Quality Improvement Organization Services

Registration is Required to Attend

Go to https://meetings-cms.webex.com/meetings-cms/k2/j.php?MTID=t9492899f8951939404979852406a6c4c and register. Upon registration, you will receive an email from “messenger@webex.com” with the dial in information and webinar link. Follow the instructions in the email to attend.

Information for Immigrant Families Webinar
December 2, 2016  2:00 – 3:00 pm ET

This webinar will provide information about the eligibility and application process for families that include immigrants and eligibility for immigrants in the Marketplace, Medicaid and CHIP.

The link for this webinar will be available on November 30, 2016. Please check the 2016 Marketplace Training Calendar for CMS Partners at marketplace.cms.gov/technical-assistance-resources/training-materials/training.html.

CMS Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum
Date: Thursday, November 17, 2016
Start Time: 2:00 PM Eastern Time (ET);
Please dial-in at least 15 minutes before call start time.
Conference Leaders: Todd Smith & Jill Darling

**This Agenda is Subject to Change**

I. Opening Remarks
Chair – Todd Smith (Center for Medicare)
Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- Flu Announcement
- SNF Payment Model Research update
  SNFTherapyPayments@cms.hhs.gov
- PBJ Update

- PBJ Policy Questions: NHStaffing@cms.hhs.gov
- PBJ Technical Questions/Issues: NursingHomePBJTechIssues@cms.hhs.gov
- PBJ Website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInitiatives/Staffing-Data-Submission-PBJ.html
· Update on implementation of Phase 1 of the Requirements for Participation for Long Term Care Facilities

· Nursing Home Convergence Strategic Plan

III. Open Q&A

**DATE IS SUBJECT TO CHANGE**

Next ODF: January 12, 2016

Mailbox: SNF_LTCODF-L@cms.hhs.gov

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

UPDATE: CMS Open Door Forums will now be available through Podcasts. Please visit: https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html. Please allow a week or so to get it posted. Thank you.

Open Door Participation Instructions:

This call will be Conference Call Only.

To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 44695728

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

Encore: 1-855-859-2056; Conference ID: 44695728

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

###

Open Enrollment Social Media

Please visit HHS’s Open Enrollment Social Media Toolkit for key open enrollment messages, graphics and video, a Social Media OE4 Event Google Calendar and more. It will be updated throughout Open Enrollment #4 and will be your one-stop-shop for #GetCovered content.

OE4 SOCIAL MEDIA EVENTS: Throughout open enrollment partners are joining us in a social media health literacy campaign that promotes health insurance coverage through information about topical health issues and the corresponding preventive services, screenings that are covered benefits. For the most up to date schedule, scripts, and questions visit to the Social Media OE4 Google Calendar

This WEEK: Social Media Events and Webinars for the week of Nov. 7 – 13.
TWITTER CHAT
@MomsRising
#WellnessWednesday
November 16, 2:00 p.m. EST

Women’s Healthy families and covered preventive services. Guest presenters American Congress of Obstetricians and Gynecologists and the Office of Women’s Health share the latest on preventive services and screenings and what you and your family need to get and stay healthy! #WellnessWed, #GetCovered Questions and graphics are attached.

As an example, here is a glimpse of upcoming OE4 social media events:

- November 16, 2:00 p.m. EST: Moms Rising hosts a Twitter chat with the American Congress of Obstetricians and Gynecologists and the Office of Women’s Health. (see below for details)
- December 5, 3:00 p.m. EST: Young Invincibles hosts #MillenialMon on LGBTQ health.
- December 5, 8:00 p.m. EST: Crohn’s & Colitis Foundation (CCFA) host a Facebook Live Chat with the American Psychological Association and SAMSHA.
- December 6, 1:00 P.m. EST: Muslim Girl hosts a Twitter Chat with expertise on women’s health from Drexel University, Generation Progress, and American Muslim Health Professionals.
- December 7, 1:00 p.m. EST: Autism Speaks hosts a Twitter Chat with Dr. Tom Novotny, HHS’s Autism Coordinator.
- December 7, 2:00 p.m. EST: Moms Rising’s #WellnessWednesday’s Twitter Chat with Out2Enroll for LGBT people of color
- December 8, 2:00 p.m. EST: Tumblr AnswerTime on #HealthyAdulting
- December 10, All Day: PPFA and Gen Z hold a day long Snapchat for National Youth Enrollment Day.

For details and additional listings please visit the OE4 Social Media Google Calendar.

Graphics & Resources for Social Media
- HHS Social Media Resources: Open Enrollment 2017
- Graphics for National Youth Enrollment Day (December 10)
- Graphics for #HealthAdulting

###

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

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

For more information and to register, visit the CMS Quality Conference webpage.

###
Marketplace Exemptions Webinar

November 30, 2016  2:00 – 3:00 pm ET

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

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

Assister Summit (Save the Date)
June 28 and 29, 2017
CMS Headquarters in Baltimore, MD

Act now: Present on quality, clinics with NRHA in Nashville
NRHA’s Rural Quality and Clinical Conference is an interactive event for rural clinicians and nurses practicing on the frontlines of rural health care, quality and performance improvement organizations and coordinators, and students. NRHA is now accepting session proposals for the Rural Quality and Clinical Conference, to be held July 12-14 in Nashville, Tenn. The theme of the event is “working together for innovations in quality and clinical care.” The submission deadline is 11:59 p.m. CST Dec. 15, 2016.

Adolescent Health 2017 Regional Conference: Investing In Adolescents and Why It Matters

Adolescence is a critical time when youth adopt behaviors that will follow them throughout the rest of their lives. It is important that youth learn to take healthy risks and develop healthy behaviors. Adults must learn how to work with youth to ensure they are creating the proper environment and providing the best resources and opportunities to help the youth of our region as they journey through this important stage of life.

Possible topics for breakout sessions:
- Adolescent Health (well visits, youth development, adolescent brain dev, health literacy)
- Positive Youth Development
- Drugs (tobacco/electronic cigarette use, alcohol)
- Injury (intention/unintentional, texting and driving, homicide)
- Mental health (suicide, trauma, depression)
- Protective Factors (leadership, volunteerism, peer mentoring)
- Today’s Youth & technology (screen time, social-media, getting youth involved, slang terms)
- Sexual Health (sexual activity, contraceptives, STIs, pregnancy prevention, pornography)
- Special Populations (human trafficking, minority health, GSA, LGBTQ, homeless)
- Teaching Youth (technology, resources, programs)
- Youth panel on adolescent health issues
- Think Act Grow (TAG)
Youth and Parent Engagement

Conference Proposal Form – Adolescent Conference
Kansas City Airport Hilton
June 8 -9, 2017

TITLE: (15 words maximum)

DESCRIPTION: (3-4 sentences)

STATE OR REGION EMPHASIS:

HOW DOES THIS FIT INTO THE CONFERENCE DESCRIPTION (3-4 sentences)

OBJECTIVES: (3-4 behavioral objectives)

VITA: (2-3 page vita)

Submit electronically by December 16, 2016

Dr. Darrel Lang
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###

Health Awareness Months, Weeks, and Days

Written by Erica Cirino | Published on August 10, 2016

Have you ever heard of Breast Cancer Awareness Month (October)? How about Eating Disorder Awareness Week (the last week of February)? Maybe World AIDS Day (December 1)?

Chances are you’re familiar with at least one of these well-known health awareness observances. But did you know the calendar is full of special months, weeks, and days that raise awareness for a variety of important health issues and conditions? They’re dates where people with certain health conditions, their loved ones, advocacy organizations, and support groups rally around a common cause: health. Educational, fundraising, and support events are often held during these times.
Here is a calendar of major health awareness months, weeks, and days:

**JANUARY**

- Cervical Health Awareness Month
- National Birth Defects Prevention Month
- National Glaucoma Awareness Month
- National Radon Action Month
- National Stalking Awareness Month
- Thyroid Awareness Month
- National Winter Sports TBI Awareness Month
- National Folic Acid Awareness Week (first full week of January)
- National Drug and Alcohol Facts Week (last week of January)

**FEBRUARY**

- American Heart Month
- AMD/Low Vision Awareness Month
- National Children’s Dental Health Month
- International Prenatal Infection Prevention Month
- African Heritage & Health Week (first week of February)
- Congenital Heart Defect Awareness Week (February 7-14)
- Condom Week (week of Valentine’s Day)
- Eating Disorders Awareness and Screening Week (last week of February)
- National "Wear Red" Day for women’s heart health (February 5)
- Teen Dating Violence Awareness Month
- World Cancer Day (February 4)
- Give Kids a Smile Day (February 5)
- National Donor Day (February 14)
MARCH

- National Colorectal Cancer Awareness Month
- National Endometriosis Awareness Month
- National Kidney Month
- Multiple Sclerosis Education Month (promoted by the Multiple Sclerosis Foundation and others)
- National Nutrition Month
- Save Your Vision Month
- Sleep Awareness Month (promoted by the National Sleep Foundation)
- Trisomy Awareness Month
- Workplace Eye Wellness Month
- National Athletic Training Month
- Patient Safety Awareness Week (March 13-19)
- National Sleep Awareness Week (March 6-13)
- Brain Awareness Week (March 14-20)
- National Poison Prevention Week (March 15-21)
- Purple Day for Epilepsy Awareness (March 26)
- National Bleeding Disorders Awareness Month
- National Cheerleader Safety Month
- Problem Gambling Awareness Month
- National School Breakfast Week (March 7-11)
- National Women and Girls HIV/AIDS Awareness Day (March 10)
- World Kidney Day (March 10)
- National Native American HIV/AIDS Awareness Day (March 20)
- American Diabetes Alert Day (March 24)
- World Tuberculosis Day (March 24)
- Tsunami Preparedness Week (March 27-April 2)

APRIL
- Alcohol Awareness Month
- National Autism Awareness Month
- National Child Abuse Prevention Month
- National Donate Life Month
- National Facial Protection Month
- Irritable Bowel Syndrome (IBS) Awareness Month
- National Minority Health Month
- Occupational Therapy Month
- National Sarcomiosis Awareness Month
- STI Awareness Month
- Sexual Assault Awareness and Prevention Month
- Sexual Assault Awareness Month of Action
- Sexual Assault Awareness Day of Action (April 5)
- Sports Eye Safety Awareness Month
- Women’s Eye Health and Safety Month
- Oral Cancer Awareness Month
- National Public Health Week (first full week of April)
- Minority Cancer Awareness Week (second full week of April)
- National Infertility Awareness Week (last full week of April)
- Every Kid Healthy Week (last full week of April)
- World Immunization Week (last week of April)
- National Infant Immunization Week (April 12-23)
- Air Quality Awareness Week (last week of April)
- National Distracted Driving Awareness Month
- National Interprofessional Health Care Month
- National Youth Violence Prevention Week (April 3-9)
- National Alcohol Screening Day (April 7)
- World Health Day (April 7)
- National Youth HIV/AIDS Awareness Day (April 10)
- World Meningitis Day (April 24)
- Every Kid Healthy Week (last week of April)

**MAY**

- American Stroke Awareness Month (promoted by the National Stroke Association)
- Arthritis Awareness Month
- Better Hearing and Speech Month
- National Celiac Disease Awareness Month
- Cystic Fibrosis Awareness Month
- Clean Air Month
- Global Employee Health and Fitness Month
- Healthy Vision Month
• Hepatitis Awareness Month
• Lupus Awareness Month (promoted by the Lupus Foundation of America)
• National Mediterranean Diet Month
• Melanoma/Skin Cancer Detection and Prevention Month
• Mental Health Month
• National High Blood Pressure Education Month
• Older Americans Month
• National Physical Fitness and Sports Month
• National Physical Education and Sport Week (first full week of May)
• National Osteoporosis Awareness and Prevention Month
• Preeclampsia Awareness Month
• Ultraviolet Awareness Month
• Children’s Mental Health Awareness Week (first full week of May)
• Food Allergy Awareness Week (second full week of May)
• Food Allergy Action Month
• National Women’s Health Week (begins on Mother’s Day)
• National Alcohol- and Other Drug-Related Birth Defects Awareness Week (begins on Mother’s Day)
• National Neuropathy Awareness Week (second full week of May)
• National Senior Health Fitness Day (last Wednesday of May)
• World Autoimmune Arthritis Day (May 20)
• Global Youth Traffic Safety Month
• National Asthma and Allergy Awareness Month
• National Teen Pregnancy Prevention Month
• North American Occupational Safety and Health Week (first full week of May)
• National Bike to School Day (May 4)
• Hand Hygiene Day (May 5)
• National Stuttering Awareness Week (May 9-15)
• National Neuropathy Awareness Week (May 12-16)
• Cornelia de Lange Syndrome Awareness Day (April 14)
• HIV Vaccine Awareness Day (May 18)
• National Asian and Pacific Islander HIV/AIDS Awareness Day (May 19)
• National Hurricane Preparedness Week (May 22-28)
• Healthy and Safe Swimming Week (May 23-29)
• Don’t Fry Day (May 27)
• Heat Safety Awareness Day (May 27)
• World No Tobacco Day (May 31)

JUNE

• Cataract Awareness Month
• Fireworks Safety Month (June 1-July 4)
• Hernia Awareness Month
- Men’s Health Month
- Myasthenia Gravis Awareness Month
- National Aphasia Awareness Month
- National Congenital Cytomegalovirus Awareness Month
- National Safety Month
- National Scleroderma Awareness Month
- Scoliosis Awareness Month (promoted by National Scoliosis Foundation and other scoliosis awareness foundations)
- Helen Keller Deaf-Blind Awareness Week (last week of June)
- Men’s Health Week (second week of June)
- National Cancer Survivors Day (first Sunday of June)
- PTSD Awareness Month
- Alzheimer’s and Brain Awareness Month
- National Rip Current Awareness Week (June 5-11)
- National Lightning Safety Awareness Week (June 19-25)
- World Sickle Cell Day (June 19)

JULY

- Cord Blood Awareness Month
- International Group B Strep Throat Awareness Month
- Juvenile Arthritis Awareness Month
- National Cleft & Craniofacial Awareness & Prevention Month
- World Hepatitis Day (July 28)

AUGUST

- Children’s Eye Health and Safety Month
- National Breastfeeding Month
- National Immunization Awareness Month
• Psoriasis Awareness Month
• World Breastfeeding Week (first week of August)
• National Health Center Week (second full week of August)
• Gastroparesis Awareness Month
• Contact Lens Health Week (August 22-26)

SEPTEMBER

• National Atrial Fibrillation Awareness Month
• Childhood Cancer Awareness Month
• National Food Safety Education Month
• Fruit and Veggies—More Matters Month
• Healthy Aging Month
• National ITP Awareness Month
• Blood Cancer Awareness Month (promoted by the Leukemia and Lymphoma Society)
• National Cholesterol Education Month
• Ovarian Cancer Awareness Month
• National Pediculosis Prevention Month/Head Lice Prevention Month
• Prostate Cancer Awareness Month
• National Recovery Month
• National Sickle Cell Month
• National Traumatic Brain Injury Awareness Month
• National Yoga Awareness Month
• Newborn Screening Awareness Month
• Whole Grains Month
• World Alzheimer’s Month
• Sepsis Awareness Month
• Usher Syndrome Awareness Day (third Saturday)
• National Suicide Prevention Week (September 5-11)
• World Suicide Prevention Day (September 10)
• World Sepsis Day (September 13)
• National Childhood Obesity Awareness Month
• National Preparedness Month
• Pain Awareness Month
• Sexual Health Awareness Month
• Sports Eye Safety Month
• National Celiac Disease Awareness Day (September 13)
• Rape, Abuse & Incest National Network (RAINN) Day (September 15)
• National Farm Safety & Health Week (September 18-24)
• National HIV/AIDS and Aging Awareness Day (September 18)
• Get Ready Day (September 20)
• National School Backpack Awareness Day (September 21)
• Falls Prevention Day (September 22)
• Family Health and Fitness Day (September 24)
• Malnutrition Awareness Week (September 26-30)
• National Women’s Health and Fitness Day (September 28)
• World Rabies Day (September 28)
• World Heart Day (September 29)
• Sport Purple for Platelets Day (September 30)
• Polycystic Ovary Syndrome (PCOS) Month

OCTOBER

• National Breast Cancer Awareness Month
• National Down Syndrome Awareness Month
• Eye Injury Prevention Month
• Health Literacy Month
• Healthy Lung Month
• Home Eye Safety Month
• National Physical Therapy Month
• Sudden Infant Death Syndrome (SIDS) Awareness Month
• Spina Bifida Awareness Month (promoted by the Spina Bifida Association)
• Pregnancy and Infant Loss Awareness Month
• Domestic Violence Awareness Month
• National ADHD Awareness Month
• Mental Illness Awareness Week (first full week of October)
• Bone and Joint Health National Action Week (October 12-20)
• National Health Education Week (third full week of October)
• International Infection Prevention Week (October 16-22)
• Respiratory Care Week (last full week of October)
• Red Ribbon Week (last week of October)
• World Mental Health Day (October 10)
• Pregnancy and Infant Loss Awareness Day (October 15)
• National Bullying Prevention Month
• National Dental Hygiene Month
• National Medical Librarians Month
• International Walk to School Day (October 5)
• National Depression Screening Day (October 6)
• Metastatic Breast Cancer Awareness Day (October 13)
• National Latino AIDS Awareness Day (October 15)
• World Food Day (October 16)
• National Healthcare Quality Week (October 17-22)
• National Health Education Week (October 17-21)
• World Pediatric Bone and Joint Day (October 19)
• International Stuttering Awareness Day (October 22)
• Red Ribbon Week (October 23-31)
• World Psoriasis Day (October 29)

NOVEMBER

• National Alzheimer’s Disease Awareness Month
• American Diabetes Month
• Chronic Obstructive Pulmonary Disease (COPD) Awareness Month
• Diabetic Eye Disease Month
• National Epilepsy Awareness Month
• National Family Caregivers Month
• National Healthy Skin Month
• National Hospice Palliative Care Month
• Lung Cancer Awareness Month
• Pancreatic Cancer Awareness Month
• Prostate Cancer Awareness Month
• National Stomach Cancer Awareness Month
• Prematurity Awareness Month
• Global Antibiotic Awareness Week (November 14-20)
• GERD Awareness Week (Thanksgiving week)
• Great American Smokeout (third Thursday of November)
• World Prematurity Day (November 17)
• Bladder Health Month
• International Survivors of Suicide Day (November 19)
• National Family Health History Day (November 24)

DECEMBER

• Crohn’s and Colitis Awareness Week (December 1-7)
- Safe Toys and Gifts Month
- National Influenza Vaccination Week (first full week of December)
- World AIDS Day (December 1)
- National Handwashing Awareness Week (December 4-10)
- References:

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

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**HRSAs' Open Funding Opportunities**
*Rural Health Network Development Program (HRSA-17-018)* - Closing Date: November 28, 2016

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

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