

Further, the TMA required adjustments to IPPS rates going forward—called prospective adjustments—so that these excess payments are not permanently incorporated into future inpatient payment rates. The Medicare Actuary estimates that the cumulative effect of documentation and coding increased spending by 5.4 percent. CMS has already applied a -0.6 percent adjustment in FY 2008 and a -0.9 percent adjustment in FY 2009 (for a total -1.5 percent adjustment). Therefore, a prospective adjustment of -3.9 percent is required to ensure that future rates do not continue to incorporate past overpayments due to documentation and coding.

PROPOSED ADJUSTMENT FOR FY 2012: CMS is now proposing to complete the recoupment of the excess FY 2008 and FY 2009 spending that was initiated in FY 2011. As explained above, CMS applied an adjustment of -2.9 percent in FY 2011 to recoup one-half of the 5.8 percent increase in FY 2008 and 2009 aggregate payment due to changes in hospital coding practices that did not reflect increases in patients' severity of illness. The recoupment adjustments are not permanent adjustments to hospital rates; therefore, the FY 2011 adjustment must be restored to FY 2012 IPPS rates to prevent this recoupment from continuing. Thus, CMS is proposing to complete the recoupment adjustment by implementing the remaining -2.9 percent adjustment, in addition to removing the effect of the -2.9 percent adjustment finalized for FY 2011. Because these adjustments will, in effect, balance out, there will be no year-to-year change in the standardized amount due to this recoupment adjustment.

Additionally, CMS is now proposing to make a prospective adjustment of -3.15 percent for FY 2012 to remove much of the effect of increased aggregate payments in FY 2008 and 2009 due to changes in hospital coding practices that did not reflect increases in patients' severity of illness. Although CMS has the authority to make the full prospective adjustment of -3.9 percent to the FY 2012 rates, CMS believes it is prudent to phase-in the prospective adjustment in order to mitigate the effects of significant downward adjustments on hospital. CMS is requesting public comment on its proposal.

CMS is also proposing to make a prospective documentation and coding adjustment of -2.5 percent to the hospital specific rates for Medicare Dependent Hospitals and Sole Community Hospitals and -1 percent to the capital Federal rate applicable to all hospitals for FY 2012 to account for the estimated increase in payments that has occurred due to the adoption of the MS-DRGs. These complete the prospective adjustments for documentation and coding due to the MS-DRGs for hospital specific rates and the capital Federal rates. CMS is not proposing a documentation and coding adjustment for LTCHs because based on an analysis of most recent available data, it does not appear that an adjustment for the effect of documentation and coding in FY 2010 is warranted.

The proposed rule was placed on display at the Federal Register today, and can be found under Special Filings at:

www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

CMS will accept comments on the proposed rule until June 20, and will respond to comments in a final rule to be issued no later Aug. 1, 2011.

For more information, please see:

www.cms.gov/AcuteInpatientPPS/01_overview.asp.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
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Washington, DC 20201



Office of Media Affairs

MEDICARE FACT SHEET

FOR IMMEDIATE RELEASE
Apr. 19, 2011

Contact: CMS Office of Media Affairs
(202) 690-6145

Proposals to improve quality of care furnished during inpatient hospital stays

OVERVIEW: On Apr. 19, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would revise policies and payment rates for general acute care hospitals that are paid for inpatient services under the Inpatient Prospective Payment System (IPPS), effective for discharges in fiscal (FY) 2012 – that is, on or after Oct. 1, 2011. The proposed rule would also update payment policies and rates for Long-term Care Hospitals (LTCHs) under the LTCH Prospective Payment System (LTCH PPS).

The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 420 LTCHs, would generally be effective for discharges occurring on or after Oct. 1, 2011. Under the proposed rule, CMS projects that Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2012 would decrease by a projected \$498 million or 0.5 percent between FY 2011 and FY 2012. This reflects a proposed hospital update of 1.5 percent (based on a projected increase of 2.8 percent for inflation in hospital costs, reduced by a multi-factor productivity adjustment of 1.2 percent and an additional 0.1 percent in accordance with the Affordable Care Act), increased by 1.1 percent in response to litigation, as well as a -3.15 percent documentation and coding adjustment. This documentation and coding adjustment is consistent with a statutory provision that requires CMS to adjust payments to remove the effect of increased aggregate payments due to changes in documentation and coding that did not reflect increases in patients' severity of illness after adoption of the MS-DRGs. Medicare payments to LTCHs in FY 2012 are projected to increase by \$95 million or 1.9 percent.

In addition to promoting accurate payment for inpatient services to Medicare beneficiaries, the proposed rule would strengthen the relationship between payment and quality of service in a number of ways. First, the proposed rule includes proposals that are part of a new Readmissions Reduction Program required by the Affordable Care Act. Second, it would expand the quality measures that hospitals must report under the Hospital Inpatient Quality Reporting (IQR)

-More-

Program – formerly called the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program - in order to receive the full update to the standardized amount in FYs 2014 and 2015. Under the Medicare law, the update for hospitals that choose not to participate in the voluntary reporting program or that do not meet program requirements includes (until FY 2015) a two percentage point reduction. As detailed above, the proposed rule proposed an update of -1.5 percent. Therefore, CMS is proposing that hospitals that do not successfully report the quality measures will receive updates currently projected to be -0.5 percent (that is, the projected increase of 2.8 percent for inflation in hospital costs, reduced by two percentage points for non-compliance with the IQR program, and further reduced by a multi-factor productivity adjustment of 1.2 percent and the additional required 0.1 percent).

Finally, the proposed rule would add one category of conditions to the list of hospital-acquired conditions (HACs) in FY 2012 for purposes of the HACs payment policy. This policy prevents hospitals from being paid at an enhanced rate for treating a beneficiary if the sole reason for the higher payment is the occurrence, during the beneficiary's hospital stay, of one of conditions on the HACs list. The proposed HAC is Acute Renal Failure after Contrast Administration (also known as contrast-induced acute kidney injury, or CI-AKI), which is an abrupt deterioration in renal function that can be associated with the use of iodinated contrast medium.

The proposed rule also contains a proposal to create a new quality reporting program, as authorized by the Affordable Care Act, that would apply to hospitals that are paid under the LTCH PPS.

This year, CMS expects to build on these quality efforts by implementing a new Hospital Value-Based Purchasing (HVBP) program, authorized by the Affordable Care Act, that will provide additional incentives to hospitals to improve the way care is delivered. CMS issued a proposed rule for the HVBP program in January and plans to issue a final rule in the near future. The IPPS proposed rule being issued today[?] contains additional proposals related to the HVBP program.

This fact sheet discusses the provisions in the proposed rule that are intended to promote continued improvement in the quality and safety of care that beneficiaries receive during inpatient hospital stays. Other policy and payment proposals included in the proposed rule are addressed in a separate fact sheet that is available on the CMS Web page at:

www.cms.gov/apps/media/fact_sheets.asp.

READMISSIONS REDUCTION PROGRAM REQUIRED BY THE AFFORDABLE CARE ACT:

Section 3025 of the Affordable Care Act established a new Hospital Readmissions Reduction Program, under which payments to certain hospitals will be reduced to account for excess

readmissions. These payment adjustments will apply to discharges on or after Oct. 1, 2012 (FY 2013). This year, CMS is proposing a number of policies as part of the new program, including a proposal to select three “measures of readmission” for the first year of the program: acute myocardial infarction (AMI) or heart attack, heart failure, and pneumonia. In addition, CMS is also proposing a methodology for calculating excess readmissions. CMS plans to continue implementation of this program in future rulemaking.

INPATIENT QUALITY REPORTING PROGRAM FOR ACUTE CARE HOSPITALS:

BACKGROUND: The Hospital Inpatient Quality Reporting (IQR) Program (formerly, the Reporting Hospital Quality Data for Annual Payment Update Program or RHQDAPU) and HACs initiatives represent significant steps toward implementing value-based purchasing (VBP) in Medicare. VBP is intended to promote high quality, safe, patient-centered care, while reducing costs through efficient provision of care and avoidance of preventable adverse events that not only increases the burden of illness on the patient and his or her caregivers, but also greatly increases health care spending.

The IQR Program grew out of the Hospital Quality Initiative developed by CMS in consultation with hospital groups. Participation in the program is voluntary, but after initial levels of participation proved disappointing, Congress added a financial incentive to the program in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Under the MMA, hospitals that chose not to participate or failed to meet the criteria for successful reporting received a 0.4 percentage point reduction to the applicable percentage increase. The Deficit Reduction Act of 2005 increased this reduction to 2.0 percentage points. Since the implementation of the financial incentive, hospital participation has increased to 99 percent and, of participating hospitals, 97 percent are receiving the full update to the standardized amount in FY 2011.

In the meantime, the IQR measure set has grown from a starter set of 10 quality measures in 2004 to the current set of 60 measures. The 60 measures include chart-abstracted measures (heart attack, heart failure, pneumonia, surgical care improvement), claims-based measures (mortality and readmissions measures for heart attack, heart failure, pneumonia; AHRQ Patient Safety Indicators and Inpatient Quality Indicators; nursing sensitive care), a survey-based measure (patient satisfaction), and structural measures (participation in a cardiac surgery, stroke care, and nursing sensitive care registry).

QUALITY AND MEASUREMENT STRATEGY: The proposals in the proposed rule focus on several fundamental CMS and Administration priorities:

- Implementing Affordable Care Act provisions
- Eliminating redundant Federal data systems and inefficiencies through Departmental and Federal-private collaboration and system process redesign
- Eliminating preventable healthcare associated infections (HAIs) and other adverse events
- Reducing provider burden by retiring eight measures that are collected through chart abstraction and adopting more claims-based outcome measures
- Aligning the IQR with the Administration's National Quality Strategy goals.

The IPPS proposed rule makes additional proposals related to the Hospital VBP program. CMS issued a proposed rule that proposed to implement a Hospital VBP program in January 2011, and plans to issue a final rule in the near future.

With respect to the Hospital IQR Program, the IPPS proposed rule proposes to improve the alignment of the validation process with Health and Human Services (HHS) and Administration priorities by adding to the validation sample the Central Line Associated Blood Stream Infection (CLABSI) measure that it adopted for the FY 2013 Hospital IQR measure set last year. CMS is also proposing to add outcome, cost and efficiency, and HAI measures to the Hospital IQR Program. These proposals also align with the Administration's National Quality Strategy in measure proposals and priorities.

The IPPS proposed rule also proposes to expand the list of proposed measures that CMS has proposed to adopt for the FY 2014 Hospital VBP program. Specifically, the proposed rule proposes to adopt a Medicare Spending per Beneficiary measure for that program. CMS made other proposals related to the implementation of a Hospital VBP Program in a separate proposed rule issued on Jan. 7, 2011, and CMS plans to issue a final rule with respect to those proposals in the near future.

SUMMARY OF PROPOSED CHANGES TO IPPS IQR:

Proposed Improvements to Program Administration - In the FY 2012 IPPS/LTCH proposed rule, CMS is proposing a number of changes to improve how the Hospital IQR Program operates and to reduce burden on participating hospitals. Specifically, , CMS is proposing to align the deadlines for submitting different types of data, and to reduce the time in which hospitals must submit requested records as part of the validation process in order to improve the accuracy of that process. CMS is also proposing to allow Quality Improvement Organizations to expedite

medical record requests for cases involving “serious reportable events” or other circumstances that have been identified during the course of a QIO quality of care review.

Proposed Changes to IQR Measure Set - The proposed rule would also make proposed changes to the measures to be reported for the FY 2014 and FY 2015 payment updates. Specifically, CMS is proposing to:

- Retire 8 measures for FY 2014 that CMS has proposed not to select for Hospital Value Based Purchasing
- Add 3 HAI measures over a 2 year period (2 for FY 2014, 1 for FY 2015)
- Add 1 claims-based efficiency measure for FY 2014
- Add 1 structural measure of participation in a registry for general surgery for FY 2014.
- Add Stroke and Venous Thromboembolism (VTE) chart abstracted measures for FY 2015.

These changes would increase the IQR measure set to 73 measures, streamline IQR processes and align submission requirements, which will make the IQR process less burdensome and more transparent to hospitals and QIOs. A list of all of the proposed measures to be reported is attached as Appendix A. A list of topics and measures under consideration in future years’ reporting are attached as Appendix B. A complete list of the current categories of conditions that are subject to the HAC payment policy is attached as Appendix B.

PROPOSALS FOR LTCH QUALITY REPORTING PROGRAM

The Affordable Care Act requires CMS to establish a new quality reporting program that would apply to hospitals paid under the LTCH PPS. The law requires that CMS apply a 2% reduction, beginning in FY 2014, to the annual payment update for LTCHs that fail to successfully report quality data to the Secretary. The law also requires CMS to publish, by no later than 10/01/2012, the quality measures selected for submission by LTCHs for FY 2014.

CMS is proposing to select quality measures for the LTCH quality reporting program that:

- Align with CMS’ aims for better care for the individual, better population health, and lower cost through better quality.
- Promote improved quality for priorities most relevant to LTCHs, including patient safety, avoidance of HAIs, and well-coordinated person-and-family-centered care.
- Cover important domains of care that are considered important by patients, national experts, and stakeholder input made via a number of existing outreach methods, including one or more Special Open Door Forums and Listening Sessions.

The proposed rule solicits public comment on a multi-year approach to expanding the LTCH quality reporting program. Under this proposal, CMS would collect data from Oct. 1 through Dec. 31, 2012 for the LTCH's payment determination in FY 2014 on the following proposed quality measures that focus on patient safety:

- Catheter Associated Urinary Tract Infection (CAUTI) rate per 1000 Urinary Catheter Days for Intensive Care Unit Patients.
- Central Line Associated Blood Stream Infection (CLABSI) rate per 1000 Central Line Days.
- Pressure Ulcers that are New or Have Worsened. This is the percentage of patients who have one or more stage 2-4 pressure ulcers that are new or worsened from a previous assessment.

For future years, CMS plans to consider implementing additional quality measurements using the standardized assessment instrument CARE (Continuity Assessment Record & Evaluation), as a primary data source, that could be used across all post-acute care sites to support the calculation and comparison of key quality measures related to priorities such as patient safety, patient care goals, functional outcomes, HACs, acute care hospitalization, care coordination and bundled care processes. It is also planning to consider additional measures aligning with National Quality Strategy for safer, better coordinated, affordable, person-centered care, healthy people and healthy communities, such as avoidable adverse events, prevention, patient preferences, patient/family experience of care, symptom management, coordination of care and care transitions). The proposed rule specifically identifies the following measures for possible future inclusion in the LTCH quality reporting program:

Possible Measures and Measure Topics for the LTCH Quality Reporting Program Under Consideration for Future Years	
Overarching Goal: Safety and Healthcare Acquired Conditions -- HAIs	
	HAI reporting for: <ul style="list-style-type: none">• Ventilator-associated Pneumonia• Surgical site infection rate• Multi-drug resistant organism infection

Possible Measures and Measure Topics for the LTCH Quality Reporting Program Under Consideration for Future Years (cont.)	
Overarching Goal: Safety and Healthcare Acquired Conditions: Avoidable Adverse Events and Serious Reportable Events	
	<ul style="list-style-type: none">● Unplanned acute care hospitalizations● Mortality● Blood Incompatibility● Foreign object retained after surgery● Manifestation of poor glycemic control● Air Embolism● Falls and trauma● Venous Thromboembolism● Injuries secondary to Poly-pharmacy● Injuries related restraint use● Medication errors● Stage III and IV Pressure Ulcer
Overarching Goal: Safety and Improvement Practices for Adverse Event Reduction	
	<ul style="list-style-type: none">● Central line bundle● Ventilator bundle● Patient Immunization for Influenza● Patient Immunization for Pneumonia● Staff immunization
Overarching Goal: Safety -- NQF Endorsed Nursing Sensitive Care Measures	
	<ul style="list-style-type: none">● Patient Fall Rate● Falls with Injury● Pressure Ulcer Prevalence● Restraint Prevalence (vest and limb only)● Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract) Nursing care hours per patient day (RN, LPN, UAP)● Voluntary turnover for RN, APN, LPN, UAP● Practice Environment Scale-Nursing Work Index

The proposed rule can be downloaded from the *Federal Register* at:

www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

CMS will accept comments on the proposed rule until June 20, 2011, and will respond to them in a final rule to be issued by Aug. 1, 2011.

**PROPOSED MEASURES FOR REPORTING IN 2013 FOR
FY 2014 AND 2015 PAYMENT UPDATES**

Topic	HIQR Program Quality Measures for FY 2014 and 2015 Payment Determination (Data Collection Beginning Jan. 1, 2012 and Jan. 1, 2013)
Acute Myocardial Infarction	
	AMI-2 Aspirin Prescribed At Discharge
	AMI-7a Fibrinolytic Agent Received Within 30 Minutes Of Hospital Arrival
	AMI-8a Primary PCI Received Within 90 Minutes Of Hospital Arrival
	AMI-10 Statin Prescribed at discharge
Heart Failure	
	HF-1 Discharge Instructions
	HF-2 Evaluation of LVS Function
	HF-3 ACEI or ARB for LVSD
Pneumonia	
	PN-3b Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
	PN-6 Appropriate initial antibiotic selection
Surgical Care Improvement Program	
	SCIP INF-1 Prophylactic Antibiotic Received Within One Hour prior to Surgical Incision
	SCIP INF-2 Prophylactic Antibiotic Selection for Surgical Patients
	SCIP INF-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time (48 hours for cardiac surgery)
	SCIP INF-4 Cardiac Surgery Patients With Controlled 6am Postoperative Blood Glucose
	SCIP INF-9 Urinary Catheter Removed On Postoperative Day 1 Or Postoperative Day 2 With Day Of Surgery Being Day Zero.
	SCIP INF 10- Surgery Patients with Perioperative Temperature Management
	SCIP CARD 2- Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period
	SCIP VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
	SCIP VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours after Surgery

Topic (Cont.)	HIQR Program Quality Measures for FY 2014 and 2015 Payment Determination (Data Collection Beginning Jan. 1, 2012 (Cont.)
Patients' Experience of Care	
	HCAHPS Survey
Mortality Measures	
	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
	Heart Failure (HF) 30-Day Mortality Rate
	Pneumonia (PN) 30-Day Mortality Rate
Readmission Measures	
	30-Day All-Cause Risk Standardized Readmission Rate (RSRR) Following AMI
	30-Day All-Cause RSRR Following HF Hospitalization
	30-Day All-Cause RSRR Following PN Hospitalization
AHRQ Patient Safety Indicators, Inpatient Quality Indicators and Composite Measures	
	PSI-4 Death Among Surgical Inpatients with Serious Treatable Complications
	PSI-6 Iatrogenic Pneumothorax, adult
	PSI-11 Postoperative Respiratory Failure
	PSI-12 Postoperative PE or DVT
	PSI-14 Postoperative Wound Dehiscence
	PSI-15 Accidental Puncture or Laceration
	IQI-11 Abdominal Aortic Aneurysm (AAA) Mortality Rate
	IQI-19 Hip Fracture Mortality Rate
	Complication/Patient Safety for Selected Indicators (Composite)
	Mortality for Selected Medical Conditions (Composite)
Healthcare Associated Infections (CDC/NHSN)	
	Central Line Associated Blood Stream Infection
	*Surgical Site Infection
	**Central Line Insertion Practices Adherence Percentage
	** Catheter Associated Urinary Tract Infection
	*** Healthcare Provider Influenza Vaccination
	***Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia
	***C. Difficile Standardized Infection Ratio (SIR)
Hospital Acquired Conditions	
	Foreign Object Retained After Surgery
	Air Embolism
	Blood Incompatibility
	Pressure Ulcer Stages III&IV
	Falls And Trauma (Includes Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)

Topic (Cont.)	HIQR Program Quality Measures for FY 2014 and 2015 Payment Determination (Data Collection Beginning Jan. 1, 2012 (Cont.))
	Manifestations Of Poor Glycemic Control
Emergency Department Throughput	
	*ED-1 Median Time from ED arrival to Time of Departure from the ED for Patients Admitted to the Hospital
	*ED-2 Median Time from Admit Decision to Time of Departure from the ED for ED Patients Admitted to Inpatient Status
Prevention	
	*Immunization for Influenza
	*Immunization for Pneumonia
Structural Measures	
	Participation in a Systematic Database for Cardiac Surgery
	Participation in a Systematic Clinical Database Registry for Stroke Care
	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
	**Participation in a Systematic Database Registry for General Surgery
Medicare Spending per Beneficiary	
	**Medicare Spending per Beneficiary
Stroke	
	***STK-1 VTE Prophylaxis
	***STK-2 Antithrombotic Therapy for Ischemic Stroke
	***STK-3 Anticoagulation Therapy for A-fib/flutter
	***STK-4 Thrombolytic Therapy for Acute Ischemic Stroke
	***STK-5 Antithrombotic Therapy by the end of Hospital Day 2
	***STK-6 Discharged on Statin
	***STK-8 Stroke Education
	***STK-10 Assessed for Rehab
Venous Thromboembolism (VTE)	
	***VTE-1 VTE Prophylaxis
	***VTE-2 ICU VTE Prophylaxis
	***VTE-3 VTE Patients with Anticoagulation Overlap Therapy
	***VTE-4 Unfractionated Heparin with Dose/Labs Monitored by a Protocol
	***VTE-5 VTE Discharge Instructions
	***VTE-6 Incidence of Potentially Preventable VTE

* Measures Adopted for FY 2014 Payment Determination in FY 2011 IPPS Final Rule

** Measures Proposed for FY 2014 Payment Determination in FY 2012 IPPS Proposed Rule

*** Measures Proposed for FY 2015 Payment Determination in FY 2012 IPPS Proposed Rule

APPENDIX B

PROPOSED LIST OF HOSPITAL ACQUIRED CONDITIONS FOR FY 2012
(Items listed in *italics* represent changes from FY 2011)

Selected HAC	CC/MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) 707.24 (MCC)
Falls and Trauma: - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)

Selected HAC	CC/MCC (ICD-9-CM Codes)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis – 278.01 998.59 9 (CC) And one of the following procedure codes: 44.38, 44.39, 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, 81.54

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 3 Oct 2011 17:03:52 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James)';Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS Issues Proposed Rule for the Medicare Advantage and Prescription Drug Programs

U.S. House and Senate Notification

Monday, October 3, 2011

To: Congressional Health Staff

**From: Amy Hall, Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: CMS Issues Proposed Rule on Medicare Advantage and Prescription Drug Programs

The Centers for Medicare & Medicaid (CMS) today issued a proposed rule for the Medicare Advantage program and prescription drug benefit program (Part D) that would implement new benefits under the Affordable Care Act, increase patient protections and improve oversight, effective for Calendar Year 2013.

This proposed rule would:

- Codify existing sub-regulatory guidance for the Coverage Gap Discount Program required by Affordable Care Act.
- Expand Part D coverage to include benzodiazepines and, for specified health conditions, barbiturates, as required under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).
- Provide CMS with explicit authority to terminate poor performing Medicare Advantage and Part D sponsors that have failed to achieve at least a 3-star rating under CMS' 5-star plan rating system for a period of three years.
- Allow high-quality Fully Integrated Dual Eligible Special Needs Plans the flexibility to offer supplemental benefits beyond those currently allowed for Medicare Advantage plans to better serve people eligible for both Medicaid and Medicare. This could include benefits such as non-skilled nursing activities in the home and in-home food delivery for vulnerable beneficiaries.
- Require Part D sponsors to provide, in certain cases, the option of a daily prorated cost-sharing rate for prescriptions for fewer than 30 days. This will enable beneficiaries to receive a trial supply for initial prescriptions at a reduced cost that will allow them to see if the drug works for them.

- Require Part D sponsors submitting prescription drug event (PDE) records to include prescribers' National Provider Identifiers (NPIs). These changes would improve data collection and tracking, help better identify the prescriber of Part D medications, and assist our law enforcement partners in conducting investigations when there is suspected fraud associated with a prescription drug claim.
- Require pharmacy benefit managers under Part D to report additional financial information to increase transparency.
- Require that pharmacists working with physicians to provide drugs for long term care patients have no affiliation with any pharmacies that provide services to the long term care facility, any pharmaceutical manufacturers or distributors, or any affiliates of these entities. This will ensure that consultant pharmacists make care recommendations free from the influence of financial incentives to overprescribe drugs for patients in long term care facilities and addresses recent findings by the Office of Inspector General.

If finalized, provisions of the proposed rule will be effective for the 2013 plan year. CMS welcomes public comments to these proposed program changes; they will be accepted from all stakeholders through the close of business 60 days following the publication of the proposed rule in the Federal Register.

The full text of the proposed rule can be found at:
http://www.ofr.gov/OFRUpload/OFRData/2011-25844_PI.pdf

The press release on the proposed rule is available on the CMS web site at:
http://www.cms.gov/apps/media/press_releases.asp

If you have any questions, please contact the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 14 Dec 2011 17:19:57 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Sandy Adams (Coleman Garrison);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mccconnell.senate.gov;Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);Wade, Karen (Hagan);'Watt, Melvin';Aramanda, Alec (DeMint);'Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Issues Proposed Rule to Increase Transparency in Health Care "Sunshine Rule"

U.S. House and Senate Notification
Wednesday, December 14, 2011

To: Congressional Health Staff

From: Jennifer Boulanger
Acting Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Issues Proposed Rule to Increase Transparency in Health Care "Sunshine Rule"

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that would implement Section 6002 of the Affordable Care Act, Transparency Reports and Reporting of Physician Ownership or Investment Interests. This notice of proposed rulemaking (NPRM) would make information publicly available about payments or other transfers of value from manufacturers of drugs, devices, biologicals and medical supplies covered by Medicare, Medicaid, and CHIP (applicable manufacturers) to physicians and teaching hospitals (covered recipients).

The proposed rule would also make information publicly available about physician (or immediate family members of a physician) ownership or investment interests in applicable manufacturers and group purchasing organizations (GPOs). CMS estimates that roughly 150 drug or biologic manufacturers, 1,000 device or medical supply manufacturers, and 420 GPOs will be required to submit information to CMS on an annual basis pursuant to this provision.

The proposed rule titled "Transparency Reports and Reporting of Physician Ownership of Investment Interests," went on display this afternoon at the Office of the Federal Register's Public Inspection Desk and is available under "Special Filings," at:

www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1 or you can directly access the PDF file at:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2011-32244.pdf>

The proposed rule will be published on December 19, 2011 and CMS will accept comments until February 17, 2012.

A press release and fact sheet regarding this proposed rule are attached and can also be found at: <https://www.cms.gov/newsroom/>

If you have questions about this announcement, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 17 Feb 2011 13:16:25 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Brooks, Mo (seibenhener, lance);Newton, Andrew (Sessions);'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Rogers, Mike (hunter.walton@mail.house.gov);Sewell, Terri (Abney, Allison);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Gingery, Phil (RobertHorne@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Jack Kingston (Allison.Thigpen@mail.house.gov);Johnson, Hank (scott.goldstein@mail.house.gov);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Palazzo, Steven (Spencer Wayne);Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (susan_sweat@wicker.senate.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Jennifer_Nardi@help.senate.gov);Butterfield, G.K. (Ken.Willis@mail.house.gov);'Coble, Howard';Elmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair);Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Skouras, Spyros);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Alexander, Lamar (Lapinski, MarySumpter (HELP Committee));Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Phil Roe;Swager, Curtis (Alexander)

Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Launches Medicaid Recovery Audit Contractor (RAC) Webpage

U.S. House and Senate Notification
Thursday, February 17, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Launches Medicaid Recovery Audit Contractor (RAC) Webpage

Today, the Centers for Medicare & Medicaid Services (CMS) posted a new, interactive webpage that will serve as a public information source on the status of state Medicaid Recovery Audit Contractor (RAC) programs. Medicaid RACs are contractors, working for States, that will audit payments made to health care providers to identify Medicaid payments that may have been underpaid or overpaid, and recover overpayments, similar to the RAC program in Medicare.

The new webpage provides information about each State's RAC program. Initially, the webpage's contents will reflect State activity in establishing RAC programs and offer descriptions of their programs as provided in their Medicaid State Plan amendments. In the future, CMS expects the page to expand and reflect performance data for each State's RAC program, such as the type of Medicaid claims that were reviewed, and the amount of overpayments that were recovered. This information will allow States to monitor the performance of their RAC program and allow the public and other stakeholders to be informed of the results.

The new webpage is located at: www.cms.gov/medicaidracs/home.aspx.

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 25 Jan 2012 16:37:33 -0500
To: Foster, Robert B. (CMS/CQISCO);Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Sandy Adams (Coleman Garrison);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (keenana.austin@mail.house.gov);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mccconnell.senate.gov;Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;'McHenry, Patrick';McIntyre, Mike (Milligan, Blair);Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);Wade, Karen (Hagan);'Watt, Melvin';Aramanda, Alec (DeMint);'Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan

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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Posts Initial Results of FY 2012 SNF Policy Changes
Attachments: SNF Monitoring FY 2012 first quarter.pdf

U.S. House and Senate Notification
Wednesday, January 25, 2012

To: Congressional Health Staff

From: Jennifer Boulanger
Acting Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Posts Initial Results of FY 2012 SNF Policy Changes

In the fiscal year (FY) 2012 Skilled Nursing Facility Prospective Payment System (SNF PPS) final rule, CMS committed to monitoring the impact of our FY 2012 policy changes on various aspects of the SNF PPS. Specifically, CMS committed to monitoring the impact of the following FY 2012 policy changes including the recalibration of the parity adjustment, allocation of group therapy and changes to the Minimum Data Set (MDS) including the introduction of the Change-of-Therapy (COT) Other Medicare Required Assessment (OMRA).

Analyses of first quarter FY 2012 data indicate the following:

- The recalibration of the parity adjustment in the FY 2012 final rule was on target. More specifically, using the full FY 2011 claims data produces a parity adjustment of 19.52 percent instead of the 19.84 percent used to establish the FY 2012 payment rates. If the full year's data were used to set the FY 2012 payment rates, the rates would be slightly lower than the rates currently in effect.
- First quarter FY 2012 utilization is not significantly different from that observed in FY 2011.
- Contrary to the claim that utilization in the higher payment therapy groups would decrease as a result of the changes included in the FY 2012 final rule, the percentage of service days in the Ultra-High Rehabilitation Resource Utilization Groups (RUGs) is slightly higher in FY 2012 than FY 2011.
- In the FY 2012 rule, CMS implemented a policy to allocate time across residents when group therapy is furnished, similar to how time is allocated for concurrent therapy. Initial FY 2012 data indicate that facilities that had been furnishing group therapy in FY 2011 are now providing individual therapy almost exclusively.
- The COT OMRA represents approximately 10 percent of all assessment types reflecting possibly less burden on SNFs than estimated in the FY 2012 final rule.

More information about the findings is attached. The attached document and the data are also posted on the CMS website at http://www.cms.gov/SNFPPS/02_Spotlight.asp#TopOfPage. (Click the SNF Monitoring link under the Downloads section on the bottom of the page.)

Please contact the CMS Office of Legislation if you have any questions about this posting at 202-690-8220. Thank you.

FY 2012 SNF PPS Monitoring Activities

Introduction:

In the FY 2012 SNF PPS final rule, we committed to monitoring the impact of our FY 2012 policy changes on various aspects of the SNF PPS. Specifically, we committed to monitoring the impact of the following FY 2012 policy changes including the recalibration of the parity adjustment, allocation of group therapy and changes to the MDS including the introduction of the Change-of-Therapy (COT) Other Medicare Required Assessment (OMRA).

We present results below using the full FY 2011 data, as well as an initial look at the first quarter of FY 2012.

RUG Distributions:

FY 2011 Parity Adjustment with full year's data

The FY 2012 final rule used approximately 8 months worth of data to recalibrate the parity adjustment. Now that FY 2011 is over, we recalculated the parity adjustment based on the full year of FY 2011 data. The recalculated parity adjustment based on the full set of FY 2011 data would result in an adjustment of 19.52 percent, not significantly different from the 19.84 percent adjustment used to determine the FY 2012 case-mix weights.

FY 2012 first quarter utilization

- **Overall patient case mix is not significantly different from that observed in FY 2011**

Table 1 below illustrates a breakdown of the SNF case-mix distributions of service days by the major RUG classification categories for the full year of FY 2011 and for the first quarter of FY 2012.

Table 1: SNF Case-Mix Distributions by Major RUG-IV Category

	FY 2011	FY 2012
Rehabilitation Plus Extensive Services	2.38%	1.78%
Rehabilitation	89.5%	88.9%
Extensive Services	0.6%	0.6%
Special Care	4.0%	4.7%
Clinically Complex	2.1%	2.2%
Behavioral Symptoms and Cognitive Performance	0.3%	0.3%
Reduced Physical Function	1.2%	1.4%

As illustrated in Table 1, there have been small decreases in both the Rehabilitation and Rehabilitation Plus Extensive Services categories, and increases in some of the medically-based RUG categories, most notably Special Care. It should be noted that the recalibration of the parity adjustment applied only to those RUG-IV groups connected to therapy (Rehabilitation Plus Extensive Services and Rehabilitation). This caused a shift in

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the hierarchy of nursing case-mix weights among the various RUG-IV groups. Since SNFs are permitted to “index maximize” when determining a resident’s RUG classification (i.e., they are permitted to choose the RUG with the highest per diem payment, of those for which the resident qualifies), it is possible that the aforementioned case-mix distribution shifts are due to residents that had previously been classified into therapy groups but now index maximize into nursing groups instead.

○ **The percentage of residents in Ultra-High Rehabilitation has increased from FY 2011**

While the percentage of residents classifying into therapy groups has decreased slightly (at least partly due to index maximization), there has also been an increase in the percentage of days at the highest therapy level. This is illustrated in Table 2 below.

Table 2: SNF Case-Mix Distribution for Therapy RUG-IV Groups, by Minor RUG-IV Therapy Categories

	FY 2011	FY 2012
Ultra-High Rehabilitation (≥ 720 minutes of therapy per week)	46.2%	46.7%
Very-High Rehabilitation (500 – 719 minutes of therapy per week)	27.3%	27.3%
High Rehabilitation (325 – 499 minutes of therapy per week)	10.9%	10.4%
Medium Rehabilitation (150 – 324 minutes of therapy per week)	7.4%	6.3%
Low Rehabilitation (45 – 149 minutes of therapy per week)	0.1%	0.1%

Although there have been decreases in the High and Medium therapy RUG-IV categories some of the decrease may be due to index maximization into the Special Care category.

Group Therapy Allocation:

To more accurately account for resource cost and to equalize the payment incentives across therapy modes, we allocated group therapy time beginning in FY 2012. We anticipated that this policy would result in some change to the type of therapy mode used for SNF residents. As noted in the section above, we have not observed any drop in patient case mix. However, as illustrated below in Table 3, **providers have significantly changed the mode of therapy since our STRIVE study (2006-2007)**. During FY 2011, we implemented the allocation of concurrent therapy without the allocation of group therapy and providers shifted from concurrent therapy to group therapy. Initial FY 2012 data indicate that after the allocation of group therapy facilities are providing individual therapy almost exclusively.

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Table 3: Mode of Therapy Provision

	STRIVE	FY 2011	FY 2012
Individual	74%	91%	99%
Concurrent	25%	1%	1%
Group	<1%	8%	0%

MDS 3.0 Changes:

In FY 2012, we introduced a new assessment called the COT OMRA to accurately capture the therapy services provided to SNF residents. For all residents receiving skilled therapy services, SNFs are required to conduct an informal check each week of the amount of therapy that a given resident received to ensure that the resident received enough therapy to maintain their qualification in their designated RUG-IV therapy classification. In cases where the resident's therapy is not consistent with their prior RUG-IV therapy classification, then the SNF must complete a COT OMRA to reclassify the resident into the appropriate RUG-IV therapy category. The COT OMRA changes payment retrospectively for the 7 day observation period and prospectively until a new assessment is done.

Table 4 below shows the distribution of all MDS assessment types as a percent of all MDS assessments. We note that the first part of FY 2012 quarter one included a transition period for the new policies, and therefore may not be entirely representative of all of FY 2012.

Table 4: Distribution of MDS assessment types

	FY 2011	FY 2012
Scheduled PPS assessment	95%	85%
Start-of-Therapy (SOT) assessment	2%	2%
End-of-Therapy (EOT) assessment (w/o Resumption)	3%	3%
Combined SOT/EOT	0%	0%
End-of-Therapy assessment (w/ Resumption) (EOT-R)	N/A	0%
Combined SOT/EOT-R	N/A	0%
Change-of-Therapy (COT) assessment	N/A	10%

In the FY 2012 SNF PPS final rule, we estimated that approximately 884,492 COT OMRAs would be submitted during FY 2012, based on an estimate of 62 COT OMRAs per facility per year for 14,266 SNF facilities (76 FR 49534). Based on the data presented in Table 4 and assuming that the number of COT OMRAs per quarter remains constant, we will have overestimated the total number of COT OMRAs that will be necessary in a given year. We will continue to monitor the number of COT OMRAs.

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 29 Aug 2016 20:50:17 +0000
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Palmer, Gary (Cari Kelly);Roby, Martha (Sophie Trainor);Rogers, Mike (Haley Wilson);Sessions, Jeff (Emily_Mcbride@sessions.senate.gov);Sewell, Terri (Hillary Beard);Shelby, Richard (Dayne Cutrell);Bilirakis, Gus;Bilirakis, gus (Kristin Seum);Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Edward Kim);cesar.gonzalez@mail.house.gov;Clawson, Curt (Alyssa Wootton);Crenshaw, Ander (Catherine Skitsko);Curbelo, Carlos (Ashley Rose);DeSantis, Ron (Becca Brown);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Gram, Gwen (hill.thomas@mail.house.gov);Grayson, Alan (Racalto, Joe);Hastings, Alcee (Kevin Ashley);Hastings, Alcee (Larissa Ferrell);Hastings, Alcee (Matthew Price);John Mica (Casey.Brinck@mail.house.gov);Jolly, David (Ian Manzano);Kobernat, Dolly (Bill Nelson);Malmgren, Corey (Bill Nelson);Mekhdjavakian, Taleen (Bill Nelson);Mica, John (Brian Waldrip);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Alyssa Wang);Nugent, Richard (Danielle Doheny);Posey, Bill (Anna Schartner);Posey, Bill (Kapavik, Christen);Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (Tim Cummings);Rubio, Marco (Eduardo Sacasa);Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Rosalyn Kumar);Wasserman Schultz, Debbie (Sarah Arkin);Wasserman Schultz, Debbie (Sarah Farhadian);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Wilson, Frederica (Kyle Johnson);Allen, Rick (cameron.bishop@mail.house.gov);Allen, Rick (Hunter, Katie);Bartolomeo, Jordan (Isakson);Bishop, Sanford (jonathan.halpern@mail.house.gov);Carter, Buddy (chase.cannon@mail.house.gov);Collins, Doug (Jennifer Lackey);Collins, Doug (Katie Evans);David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov);David Scott (lauren.lattany@mail.house.gov);Eunice, John (Perdue);Graves, Tom (Bo Butler);Graves, Tom (Jason Murphy);Hice, Jody (Michael Calvo);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (Arya Hariharan);Lewis, John (Thomas Dorney);Loudermilk, Barry (Colin Carr);Loudermilk, Barry (Easton Randall);Price, Tom (Amanda Street);Price, Tom (Ashley Palmer);Price, Tom (DiBlasio, Carla);Scott, Austin (Beal, Mary Dee);Scott, David (Cramer, Martha);Westmoreland, Lynn (Porter, Amber);Woodall, Rob (Janet Rossi);Barr, Andy (Francis Brooke);Burkhalter, Natalie (Paul);Guthrie, Brett (Megan Jackson);Lewis, Katie (Paul);Massie, Thomas (Seana Cranston);'McConnell, Mitch';McConnell, Mitch (Natalie McIntyre);Paul, Rand (Bonnie Honaker);shannon.rickett@mail.house.gov;Whitfield, Ed (Cassie Leonard);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Allred, SarahLloyd (Wicker);Bennie Thompson (Cory Horton);Cochran, Thad (Elizabeth Joseph);Cochran, Thad (Mary Henson);Harper, Gregg (Jordan See);Henry, Elizabeth (Cochran);Kelly, Trent (Tara Gaddis);Palazzo, Steven (Patrick Large);'Thompson, Bennie';(Esther_Clark@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Alma (Margaret Franklin);Adams, Alma (Sandra Brown);Adams, Alma (Shaniqua McClendon);Blackburn, Marsha (Kristi Thompson);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Angela Boothe);Burr, Richard (Colin Rom);Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Dennis Sills);Butterfield, G.K. (Taylor, Annette);Holding, George (Jason Cooke);Hudson, Richard (Preston Bell);Jones, Walter (joshua.bowlen@mail.house.gov);'McHenry, Patrick';Meadows, Mark (Zach Enos);Pittenger, Robert (Michelle Jelnicky);Price, David;Price, David (Nora Blalock);Rouzer, David (Kyle

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS proposes new standards to strengthen the Marketplace for 2018

U.S. House and Senate Notification

Monday, August 29, 2016

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS proposes new standards to strengthen the Marketplace for 2018

The Centers for Medicare & Medicaid Services (CMS) today issued the proposed annual Notice of Benefit and Payment Parameters for 2018, which proposes additional steps to strengthen the Health Insurance Marketplace. CMS is issuing this rule earlier in the calendar year in order to provide more certainty to the Marketplace as it continues to mature.

Beginning in 2017, the proposed policies will take important steps to strengthen one of the Marketplace's key tools for protecting consumers' access to high-quality, affordable coverage options: the risk adjustment program. The rule introduces changes that will make risk adjustment even more effective at pooling risk, allowing issuers to focus on meeting the needs of consumers. First, the rule proposes updates beginning in 2017 to better reflect the risk associated with enrollees who are not enrolled for a full 12 months. Second, beginning in 2018, the rule proposes to use prescription drug utilization data to improve the predictive ability of our risk adjustment models. Third, also beginning in 2018, the rule proposes to establish transfers that will help to better spread the risk of high-cost enrollees, a change that would improve the risk-sharing benefits of the program.

In addition to these improvements to risk adjustment, this proposed rule contains other provisions to improve the Marketplace consumer experience and strengthen the individual and small group markets as a whole. The proposed rule would give consumers additional tools for assessing the networks of competing plans; broaden availability of this year's new standardized

plan options by accommodating state cost-sharing rules; and create consumer protections for consumers enrolling through the direct enrollment channel. The proposed rule would also create multiple child age bands that address instances in which consumers could face large premium changes after turning age 21; amend the guaranteed renewability regulations to provide additional flexibility for issuers to remain in an insurance market in certain situations; and codify several special enrollment periods that are already available to consumers in order to ensure the rules are clear and to limit abuse. It also seeks information on a number of suggestions offered by issuers, consumers, providers, and others on further improving the risk pool, such as additional changes to special enrollment period policies or outreach; clarifying coordination of benefit rules between Medicare, Medicaid, and the Marketplace; and providing greater certainty on the amount of user fee revenue spent on education and outreach.

In addition, CMS also released a draft 2018 Actuarial Value (AV) calculator and Draft 2018 AV Calculator Methodology.

To view the proposed rule, visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-20896.pdf>

To view a fact sheet about the proposed rule, visit:
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-29.html>

To view the draft 2018 AV calculator and methodology (which will be live shortly at):
<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#PlanManagement>

If you have any questions, please contact the CMS Office of Legislation.

Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 29 Aug 2016 20:52:05 +0000
To: Howell, Cherie A. (CMS/OL);Rep O'Rourke;Rep. AL Green;Rep. Babin;Rep. Babin;Rep. Barton;Rep. Brady;Rep. Brady;Rep. Burgess;Rep. Burgess;Rep. Burgess;Rep. Carter;Rep. castro;Rep. Conaway;Rep. Cuellar;Rep. Culberson;Rep. Doggett;Rep. Doggett;Rep. Doggett;Rep. Eddie Bernice Johnson;Rep. Farenthold;Rep. Flores;Rep. Gene Green;Rep. Gohmert;Rep. Granger;Rep. Hensarling;Rep. Hinojosa;Rep. Hurd;Rep. Jackson Lee;Rep. Marchant;Rep. McCaul;Rep. Neugebauer;Rep. Neugebauer;Rep. Olson;Rep. Orourke;Rep. Poe;Rep. Ratcliffe;Rep. Sam Johnson;Rep. Sessions;Rep. Smith;Rep. Thornberry;Rep. Veasey;Rep. Veasey;Rep. Vela (jasey.cardenas@mail.house.gov);Rep. Weber;Rep. Williams;Sen. Cornyn;'Sen. cornyn';Sen. Cruz;Kristina.thompson@mail.house.gov;Rep. Bonamici;Rep. Bonamici;Rep. Delbene;Rep. Heck;Rep. Herrera;Rep. Kilmer;Rep. Larsen;Rep. McDermott;Rep. McMorris Rodgers;Rep. Newhouse;Rep. Reichert;Rep. Smith;Sen. Cantwell;Sen. Cantwell;Sen. Cantwell;Sen. Murray (madeleine_pannell@help.senate.gov);Rep. Blumenauer;Rep. Bonamici;Rep. Defazio;Rep. Schrader;Rep. Walden;Sen. Merkley;Sen. wyden;Rep. Bridenstine (mark.piland@mail.house.gov);Rep. Cole;Rep. Lankford;Rep. Lucas;Rep. Mullin;Rep. Russell;Sen. Inhofe;Rep. Lujan;Rep. Lujan;Rep. Lujan Grisham;Rep. Lujan Grisham;Rep. Pearce;Rep. Pearce (Patrick.cuff@mail.house.gov);'Sen. Heinrich';Sen. Udall;Sen. Udall;Rep. Abraham;Rep. Boustany;Rep. Boustany;Rep. Fleming;Rep. Garret Graves;Rep. Graves;Rep. Richmond;Rep. Scalise;Sen. Cassidy;Sen. Vitter;Rep. Labrador (Aaron.calkins@mail.house.gov);Rep. Simpson;Sen. Crapo;Sen. Risch (Rachel_burkett@risch.senate.gov);Rep. Womack;Rep. Crawford;Rep. Crawford;Rep. Hill;Rep. Westerman;Sen. Boozman;Sen. Cotton (Brian_colas@cotton.senate.gov);Rep. Young;Sen. Murkowski;Sen. Sullivan;Rep. Pearce;julie.merberg@mail.house.gov
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS proposes new standards to strengthen the Marketplace for 2018

U.S. House and Senate Notification

Monday, August 29, 2016

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS proposes new standards to strengthen the Marketplace for 2018

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Beginning in 2017, the proposed policies will take important steps to strengthen one of the Marketplace's key tools for protecting consumers' access to high-quality, affordable coverage options: the risk adjustment program. The rule introduces changes that will make risk adjustment even more effective at pooling risk, allowing issuers to focus on meeting the needs of consumers.

First, the rule proposes updates beginning in 2017 to better reflect the risk associated with enrollees who are not enrolled for a full 12 months. Second, beginning in 2018, the rule proposes to use prescription drug utilization data to improve the predictive ability of our risk adjustment models. Third, also beginning in 2018, the rule proposes to establish transfers that will help to better spread the risk of high-cost enrollees, a change that would improve the risk-sharing benefits of the program.

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To view the draft 2018 AV calculator and methodology (which will be live shortly at): <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#PlanManagement>

If you have any questions, please contact the CMS Office of Legislation.

Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 27 Jun 2013 16:51:03 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Terri Sewell (rob.nesmith@mail.house.gov);Young, M.V. (Shelby) <M.V._Young@shelby.senate.gov>;Abby.Dosoretz@mail.house.gov;Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);DeSantis, Ron (Rachel Dresen);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Grayson, Alan (Juan Lopez);Grayson, Alan (Julie Tagen);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Larry Zaragoza);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Katherine Troller);Posey, Bill;Rooney, Tom (jessica.moore@mail.house.gov);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);Wilson, Frederica (keenan.austin@mail.house.gov);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Butler, Bo (Chambliss) <Bo_Butler@chambliss.senate.gov>;Collins, Doug (Jennifer Lackey);David Scott (lauren.lattany@mail.house.gov);Doug Collins (Jason O'Rourke);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Pastor, Francie);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);Stone, Sarah (Cochran) Sarah_Stone@cochran.senate.gov;'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);Thompson, Bennie (TSMITH@mail.house.gov);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Ellmers, Renee (Josh Babb);Ellmers, Renee (Mitchell Vakerics);Hagan, Kay (mike_harney@hagan.senate.gov);Holding, George (Ryan Hart);Howard Coble (meredith.downen@mail.house.gov);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);Mark Meadows (Allison Witt) (allison.witt@mail.house.gov);'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Meadows, Mark

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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Proposes Payment Changes For Medicare Home Health Agencies For 2014
Attachments: 2014 HH PPS NPRM_Fact Sheet_06_27_2013_FINAL.PDF

U.S. House and Senate Notification
Thursday, June 27, 2013

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Proposes Payment Changes For Medicare Home Health Agencies For 2014

The Centers for Medicare & Medicaid Services (CMS) today announced proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year (CY) 2014 that would foster greater efficiency, flexibility, payment accuracy, and improved quality.

CMS projects that Medicare payments to home health agencies in CY 2014 will be reduced by 1.5 percent, or \$290 million relative to CY 2013, based on the proposed policies. The proposed decrease reflects the effects of the 2.4 percent home health payment update percentage, 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, and the effects of ICD-9-CM coding adjustments.

The rule proposes adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the NRS conversion factor as part of rebasing mandated by the Affordable Care Act. It also proposes an update to the Low-Utilization Payment Adjustment (LUPA) add-on amount, and proposes routine updates to the HH PPS payment rates such as updating the payment rates by the HH PPS payment update percentage and updating the home

health wage index for 2014. Finally, the rule proposes to remove certain diagnosis codes from the HH PPS grouper.

With respect to quality improvement, the proposed rule would add two claims-based quality measures to the Home Health Quality Reporting Program relating to hospital readmissions and Emergency Department visits with the first 30 days of a home health stay. The proposed rehospitalization measures will allow HHAs to further target patients who entered home health after a hospitalization. In addition, this rule would reduce the number of home health quality measures currently reported to home health agencies to simplify their use for quality improvement activities.

The proposed rule can be viewed at: <http://federalregister.gov/inspection.aspx>. Please be mindful this link will change once the proposed rule is published on July 3, 2013 in the *Federal Register*. CMS will accept comments on the proposed rule until August 26, 2013.

Attached please find a fact sheet with more information about the policies included in this proposed rule. Please contact the CMS Office of Legislation if you have any questions. Thank you.



FACT SHEET

FOR IMMEDIATE RELEASE
June 27, 2013

Contact: CMS Media Relations
(202) 690-6145

CMS PROPOSES PAYMENT CHANGES FOR MEDICARE HOME HEALTH AGENCIES FOR 2014

The Centers for Medicare & Medicaid Services (CMS) today announced proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year (CY) 2014 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Based on the most recent data available, CMS estimates that approximately 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies, costing Medicare approximately \$18.2 billion in 2012.

In the rule, CMS projects that Medicare payments to home health agencies in calendar year (CY) 2014 will be reduced by 1.5 percent, or \$290 million based on the proposed policies. The proposed decrease reflects the effects of the 2.4 percent home health payment update percentage (\$460 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 (\$650 million decrease), and the effects of ICD-9-CM coding adjustments (\$100 million decrease).

In addition, the rule proposes routine updates to the HH PPS payment rates such as updating the payment rates by the HH PPS payment update percentage and updating the home health wage index for 2014.

Background

To qualify for the Medicare home health benefit, a Medicare beneficiary must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical therapy, speech -language pathology, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency (HHA).

Medicare pays home health agencies through a prospective payment system that pays higher rates for services furnished to beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians as currently required for all Medicare-participating home health agencies. Home health payment rates are updated annually by the home health payment update percentage. The payment update percentage is based, in part,

on the home health market basket, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

HH PPS Grouper Refinements and ICD-10-CM Conversion

The proposed rule would remove two categories of ICD-9-CM codes from the HH PPS Grouper: diagnosis codes that are “too acute,” meaning the condition could not be appropriately cared for in a home health setting; and diagnosis codes for conditions that would not impact the home health plan of care, or would not result in additional resources when providing home health services to the beneficiary. ICD-10-CM codes will be included in the HH PPS Grouper to be used starting on October 1, 2014. The new ICD-10-CM codes will replace the existing ICD-9-CM codes used to report medical diagnoses and inpatient procedures.

Rebasing the 60-day Episode Rate

The Affordable Care Act requires that beginning in CY 2014, CMS 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. Additionally, 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) in any given year, and be fully implemented by CY 2017.

The rule proposes a reduction to the national, standardized 60-day episode rate of 3.5 percent in each year CY 2014 through CY 2017. The proposed national, standardized 60-day episode payment for CY 2014 is \$2,860.20. This reduction primarily reflects the observed reduction in the number of visits per episode since establishment of the HH PPS in 2000.

Rebasing Per-Visit Amounts

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a Low-Utilization Payment Adjustment (LUPA). The rule proposes an increase to each of the per-visit payment rates of 3.5 percent in each year CY 2014 through CY 2017 to account for changes in the costs of providing these services since the establishment of the HH PPS in 2000.

Rebasing and Updating Other Components of the HH PPS

Similar to the proposals for rebasing 60-day episodes and per-visit rates, this proposed rule would rebase the payment for NRS and update the LUPA add-on payment amount. The rule proposes a decrease in the NRS conversion factor of 2.58 percent in each year CY 2014 through CY 2017. In updating the LUPA add-on amount and proposing three LUPA add-on factors, LUPA add-on payments are estimated to increase by approximately 4.8 percent (using rebased per-visit amounts described above that were increased by 3.5 percent).

Quality Reporting

The proposed rule would add two claims-based quality measures: (1) Rehospitalization During the First 30 Days of a Home Health Stay, and (2) Emergency Department Use Without Hospital Readmission during the first 30 days of Home Health. The proposed rehospitalization measures will allow HHAs to further target patients who entered home health after a hospitalization. In

addition, this rule would reduce the number of home health quality measures currently reported to home health agencies to simplify their use for quality improvement activities.

Cost Allocations for Home Health Agency Surveys

This proposed rule would ensure that Medicaid responsibilities for home health surveys are explicitly recognized in the State Medicaid Plan. CMS seeks comment on a methodology for calculating State Medicaid programs' fair share of Home Health Agency surveys costs. For that portion of costs attributable to Medicare and Medicaid, we would assign 50 percent to Medicare and 50 percent to Medicaid, the same methodology that is used to allocate costs for dually-certified nursing homes.

For additional information about the Home Health Prospective Payment System, visit <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html>. The proposed rule can be viewed: <http://federalregister.gov/inspection.aspx>. Please be mindful this link will change once the proposed rule is published on July 3, 2013 in the *Federal Register*. CMS will accept comments on the proposed rule until August 26, 2013.

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 5 Jul 2011 16:26:49 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Palazzo, Steven (Spencer Wayne);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS Proposes Payment Changes to Medicare Home Health Services for 2012

Attachments: HHPPS press release 07 05 2011 (clean & final).pdf

U.S. House and Senate Notification
Tuesday, July 5, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Proposes Payment Changes to Medicare Home Health Services for 2012

The Centers for Medicare & Medicaid Services (CMS) today announced a number of changes to Medicare home health payments for 2012 that will promote greater efficiency and payment accuracy. Combining the effects of a market basket update, a wage index update, and reductions to the home health prospective payment system (HH PPS) rates to account for increases in aggregate case-mix that are unrelated to underlying changes in patients' health status, today's rule proposed a 3.35 percent decrease in Medicare payments to home health agencies (HHAs) for calendar year (CY) 2012.

The Affordable Care Act (ACA) mandates that CMS apply a 1 percentage point reduction to the CY 2012 home health market basket amount, which equates to a proposed 1.5 percent update for HHAs in CY 2012. CMS also proposes to further reduce HH PPS rates in CY 2012 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. Based on the updated data analysis in the proposed rule, CMS proposes to reduce HH PPS rates by 5.06 percent in CY 2012.

The proposed rule also makes structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same aggregate payments.

In a separate proposed rule announced today, CMS would align the face-to-face encounter requirement for people receiving Medicaid and Medicare home health services as required under Section 6407 of the ACA. The proposed Medicaid rule also clarifies long-standing CMS policy on locations in which home health services may be provided, and facilitates State compliance with the *Olmstead* Supreme Court decision.

Please find attached a press release regarding the two rules proposed today. They are available at: <http://federalregister.gov/inspection.aspx>.

If you have any questions about these proposed rules, please contact the CMS Office of Legislation at 202-690-5519. Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
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Office of Media Affairs

MEDICARE NEWS

FOR IMMEDIATE RELEASE

Contact: CMS Public Affairs

July 5, 2011

202-690-6145

CMS PROPOSES 2012 MEDICARE HOME HEALTH PAYMENT CHANGES

Separate *Federal Register* filing for Medicaid home health services proposed to unify ACA provisions

The Centers for Medicare & Medicaid Services (CMS) today announced a number of proposed changes to Medicare home health payments for 2012 that if finalized will promote greater efficiency and payment accuracy.

A proposed rule was displayed at the *Federal Register* today proposing a 3.35 percent decrease in Medicare payments to home health agencies (HHAs) for calendar year (CY) 2012. This would be an estimated net decrease of \$640 million compared to HHA payments in CY 2011. It would include the combined effects of market basket and wage index updates (a \$310 million increase) and reductions to the home health prospective payment system (HH PPS) rates to account for increases in aggregate case-mix that are largely related to billing practices and not related to changes in the health status of patients (a \$950 million decrease).

Provisions of the Affordable Care Act (ACA) mandate that CMS apply a one (1) percentage point reduction to the CY 2012 home health market basket amount; this would equate to a proposed 1.5 percent update for HHAs next year. As part of the HH PPS rate update, CMS also proposes to reduce HH PPS rates by 5.06 percent in CY 2012 to account for the increase in the case-mix that is unrelated to changes in patient acuity.

The Medicare HHA proposed rule would also make structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments.

“CMS’s proposal reflects our commitment to ensure that we pay accurately for Medicare home health services as we improve the structure of our payment system and decrease incentives for upcoding,” said Jonathan Blum, Deputy Administrator and Director of the Center for Medicare.

Medicare pays home health agencies through a prospective payment system (PPS) which pays at higher rates to care for those beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians; such data are currently required from all Medicare-participating home health agencies (HHAs).

Home health payment rates have been updated annually by either the full home health market basket percentage increase, or by the home health market basket percentage increase as adjusted by Congress. CMS uses the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services. The Deficit Reduction Act of 2005 requires an adjustment to the home health market basket percentage update depending on HHAs submission of quality data. The proposed home health market basket increase for CY 2012 is 1.5 percent. HHAs that submit the required quality data would receive payments based on this full home health market basket update. If an HHA does not submit quality data, the home health market basket percentage increase would be reduced by 2 percentage points to -0.5 percent for CY 2012.

Under current Medicare policy a certifying physician or an allowed non-physician practitioner must see a patient prior to certifying a patient as eligible for the home health benefit. In today's proposed rule filing, Medicare has proposed to add flexibility to allow physicians who attended to a home health patient in an acute or post-acute setting to inform the certifying physician of their encounters with the patient in order to satisfy the requirement.

In a separate proposed rulemaking filed today (CMS-2348-P), CMS would require comparable face-to-face (F2F) encounters for people receiving Medicaid home health services to adhere to the unifying nature of these provisions made under the ACA.

To qualify for the Medicare home health benefits, a beneficiary must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical or speech therapy, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency. Beneficiaries receiving Medicaid home health do not need to be homebound or require skilled care. Home health agencies participating in the Medicaid program must also adhere to Medicare conditions of participation.

Cindy Mann, director of CMS' Center for Medicaid, CHIP and Survey & Certification, said the alignment of F2F encounter requirements between the two CMS programs fulfills Section 6407 of the Affordable Care Act. "We established the Medicaid implementation of this requirement to align with Medicare's guidance to better facilitate home health services provided to individuals that are eligible for Medicare and Medicaid and to lessen the administrative burden on providers participating in both programs" Mann said.

This Medicaid regulation also clarifies long-standing CMS policy on locations and facilities in which home health services may be provided, in order for States to remain in compliance with the *Olmstead* Supreme Court decision.

The proposed rules went on display at 4:00 pm today (07/05/2011) at the *Federal Register*. The rule can be located at: <http://federalregister.gov/inspection.aspx>

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 2 Dec 2010 11:14:31 -0500
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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS Region 4 "Health Care Delivery System Reform" Listening Session Invite

Attachments: Listening Session Region IV Invitation.pdf

U.S. House and Senate Notification
Thursday, December 2, 2010

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Region 4 "Health Care Delivery System Reform" Listening Session Invite

The Centers for Medicare & Medicaid Services (CMS) Atlanta Region 4 Office will be hosting a listening session on **Thursday, December 16, 2010, from 1:00pm-2:30pm EST**, to highlight the important work CMS is undertaking around health care delivery system reform, and to gain input from stakeholders. We will spotlight three areas of interest:

- The Accountable Care Organization Shared Savings Program
- The Center for Medicare and Medicaid Innovation
- The Federal Coordinated Health Care Office

To participate on the call, please dial **1-800-837-1935** and use the participant ID: **28950540**.

Please find attached the formal invitation to the event. If you have any questions regarding this announcement, please contact the CMS Office of Legislation at (202) 690-8220. Thank you.



U.S. Department of Health & Human Services

CMS/ Centers for Medicare & Medicaid Services

Dear Colleagues:

The Centers for Medicare & Medicaid Services (CMS) is pleased to invite your participation in the following:

CMS Listening Session: Health Care Delivery System Reform

Thursday, December 16, 2010
1:00 pm to 2:30 pm (EST).

Hosted by CMS Regional Administrator, Dr. Renard Murray
featuring

Dr. Richard Gilfillan

Acting Director, Centers for Medicare and Medicaid Innovation (CMI)
and

Sharon Donovan

Federal Coordinated Health Care Office

Also including

The Department for Health and Human Services Regional Director, Anton Gunn

Call in information:

For participants – 800-837-1935

ID Code: 28950540

Because of the anticipated interest in this topic, we advise you to call in at least 15 minutes prior to start time

The purpose of this listening session is to highlight the important work CMS is undertaking around health care delivery system reform. The Affordable Care Act has given CMS new opportunities to improve the care delivery and payment system. We will spotlight three areas of interest:

- The Accountable Care Organization Shared Savings Program
- The Center for Medicare and Medicaid Innovation
- The Federal Coordinated Health Care Office

Please join CMS, HHS and a wide audience of comprised of audience of internal and external partners and stakeholders to discuss these important topics.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 2 Dec 2015 16:38:05 -0500
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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS releases 2014 National Health Expenditures

Attachments: NHE-2014-Press-Release.pdf

U.S. House and Senate Notification
Wednesday, December 2, 2015

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS releases 2014 National Health Expenditures

Today, in a study published as a Web First by *Health Affairs*, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary released its 2014 National Health Expenditures report. According to the report, in 2014, per-capita health care spending grew by 4.5 percent and overall health spending grew by 5.3 percent. Those rates are below most years prior to passage of the Affordable Care Act. In addition, consumer out-of-pocket spending grew by only 1.3 percent in 2014, as compared to 2.4 percent growth in 2013, reflecting the increased number of individuals with health coverage.

The report concludes that the acceleration in spending growth from 2013 was primarily driven by millions of new people with health insurance coverage a result of the Affordable Care Act, and by rapid rising prescription drug costs. Overall, spending on prescription drugs grew by 12.2 percent in 2014, compared to 2.4 percent growth in 2013, fueled largely by spending for new medicines, particularly for specialty drugs such as those used to treat hepatitis C. On a per-enrollee basis, overall spending increased by 3.2 percent in private health insurance and 2.4 percent for Medicare and decreased by 0.2 percent in Medicaid.

The Affordable Care Act allowed 8.7 million individuals to gain coverage in 2014 compared to 2013. As a result, the insured share of the population increased from 86.0 percent in 2013 to 88.8 percent in 2014, the highest share since 1987, according to the authors.

Overall, health care spending grew 1.2 percentage points faster than the overall economy in 2014, resulting in a 0.2 percentage-point increase in the health spending share of gross domestic product – from 17.3 percent to 17.5 percent. In the decade prior to the Affordable Care Act (2000-2009), health care spending grew by an average of 6.9 percent annually, 2.8 percentage points faster than GDP.

The report will appear at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

An article about the report also being published on December 2, 2015, by Health Affairs as a Web First at <http://www.healthaffairs.org> and will also appear in the journal's January issue.

A press release is also attached.

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201



CMS NEWS

FOR IMMEDIATE RELEASE
December 2, 2015

Contact: CMS Media Relations
(202) 690-6145 | [CMS Media Inquiries](#)

CMS Releases 2014 National Health Expenditures

Aggregate health expenditures increase as millions gain coverage and prescription drug costs increase; spending growth remains below rates seen prior to the Affordable Care Act

In 2014, per-capita health care spending grew by 4.5 percent and overall health spending grew by 5.3 percent, a study by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) published today as a Web First by *Health Affairs*. Those rates are below most years prior to passage of the Affordable Care Act. In addition, consumer out-of-pocket spending grew by only 1.3 percent in 2014, as compared to 2.4 percent growth in 2013, reflecting the increased number of individuals with health coverage.

The report concludes that the increase in spending growth from 2013 was primarily driven by millions of new people with health insurance coverage a result of the Affordable Care Act and by rapidly rising prescription drug costs. Overall, spending on prescription drugs grew by 12.2 percent in 2014, compared to 2.4 percent growth in 2013, fueled largely by spending for new medicines, particularly for specialty drugs such as those used to treat hepatitis C. On a per-enrollee basis, overall spending increased by 3.2 percent in private health insurance and 2.4 percent for Medicare and decreased by 2.0 percent in Medicaid.

“Millions of uninsured Americans gained health care coverage in 2014,” said CMS Acting Administrator Andy Slavitt, “And still, the rate of growth remains below the level in most years prior to the coverage expansion, while out-of-pocket costs grew at the fifth lowest level on record.”

The Affordable Care Act allowed 8.7 million individuals to gain coverage in 2014 compared to 2013. As a result, the insured share of the population increased from 86.0 percent in 2013 to 88.8 percent in 2014, the highest share since 1987, according to the authors.

Overall, health care spending grew 1.2 percentage points faster than the overall economy in 2014, resulting in a 0.2 percentage-point increase in the health spending share of gross domestic product – from 17.3 percent to 17.5 percent. In the decade prior to the Affordable Care Act (2000-2009), health care spending grew by an average of 6.9 percent annually, 2.8 percentage points faster than GDP.

“Today’s report reminds us that we must remain vigilant in focusing on delivering better health care outcomes, which leads to smarter spending, particularly as costs increase in key care areas, like prescription drugs costs,” added Slavitt.

Additional highlights from the report:

- **Total private health insurance expenditures** (33 percent of total health care spending) reached \$991.0 billion in 2014, and increased 4.4 percent, faster than the 1.6 percent growth in 2013 (the slowest rate since 1967). The faster rate of growth reflected the impacts of expanding coverage through Marketplace plans, health insurance premium tax credits, new industry fees, and changes to benefit designs. Per-enrollee spending increased by 3.2 percent in 2014. Average growth in per-enrollee spending was 7.4 percent from 2000-2009.
- **Medicare spending**, which represented 20 percent of national health spending in 2014, grew 5.5 percent to \$618.7 billion, a faster increase than the 3.0 percent growth in 2013. The 2014 rate of growth was driven by increased spending growth for retail prescription drugs and in Medicare Advantage. Per-enrollee spending increased by 2.4 percent. Average growth in per-enrollee spending was 7.0 percent from 2000-2009.
- **Medicaid spending** accounted for 16 percent of total spending on health and grew 11.0 percent in 2014 to \$495.8 billion, a faster increase than the 5.9 percent growth in 2013. Medicaid growth in 2014 was driven by coverage expansion under the Affordable Care Act, as 26 states plus the District of Columbia provided coverage for individuals with incomes of up to 138 percent of the federal poverty level. An estimated 6.3 million newly eligible enrollees were added to Medicaid in 2014. Per-enrollee spending decreased by 2.0 percent.
- **Out-of-pocket spending** (which includes direct consumer payments such as copayments, deductibles, and spending not covered by insurance, excluding premiums) grew 1.3 percent in 2014 to \$329.8 billion, slower than annual growth of 2.1 percent in 2013. The slowdown in 2014 was influenced by the expansion of insurance coverage and the corresponding drop in the number of individuals without insurance.
- **Retail prescription drug spending** accelerated in 2014, growing 12.2 percent to \$297.7 billion, compared to 2.4 percent growth in 2013. Rapid growth in 2014 was due to increased spending for new medicines (particularly for specialty drugs such as those used to treat hepatitis C), a smaller impact from patent expirations, and price increases for brand-name drugs. Private health insurance, Medicare, and Medicaid spending growth for prescription drugs all accelerated in 2014.

- In 2014, **households** and the **federal government** accounted for the largest shares of spending (28 percent each), followed by **private businesses** (20 percent), and **state and local governments** (17 percent). The federal government share increased from 26 percent in 2013 due mainly to Medicaid expansion (which was financed 100 percent by the federal government) and health insurance premium tax credits.

The OACT report will appear at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

An article about the study also being published on December 2, 2015, by Health Affairs as a Web First <http://www.healthaffairs.org> and will also appear in the journal's January issue.

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS Releases 2014 Rate Announcement and Final Call Letter for MA and Part D programs

**U.S. House and Senate Notification
Monday, April 1, 2013**

To: Congressional Health Staff

**From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: CMS Releases 2014 Rate Announcement and Final Call Letter for MA and Part D programs

Today, the Centers for Medicare & Medicaid Services (CMS) issued the 2014 Rate Announcement and Final Call Letter for the Medicare Advantage (MA) and prescription drug benefit (Part D) programs. The announcements set a stable path for MA and implement a number of policies designed to improve payment accuracy. Health care spending has been slowing across the nation, with Medicare spending per beneficiary growing at only 0.4 percent per capita in 2012. For the first time since inception of the Part D program, the deductible for the defined standard plan will be lower in 2014 than in previous years.

After careful consideration of public comments, policies finalized in the Rate Announcement and Final Call Letter include:

Payments to Plans

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- The final estimate of the combined effect of the MA growth percentage and the fee-for-service growth percentage is 3.3 percent. These growth rates assume a zero percent change for the 2014 physician fee schedule (PFS) by taking into account the likely congressional override of the schedule physician payment reduction.
- CMS will continue implementation of payment based on quality in the MA program. Over the last year, the number of four and five star plans has increased significantly, with 127 such plans in MA in 2013, 21 more than the prior year.
- CMS will continue the phased-in alignment of MA benchmarks with Medicare fee-for-service (FFS) costs, and as proposed will implement an MA coding pattern difference adjustment of 4.91% for payment year 2014.

Improved Risk Adjustment Model

CMS will implement the proposed updated and clinically revised risk adjustment model which also limits opportunities for MA plans to be paid more for coding differences with Medicare fee-for-service. As a transitional step, the risk scores for 2014 will be a blend of those calculated under the 2014 and 2013 models. CMS will continue to use the same risk adjustment model for PACE in 2014 used in 2012 and 2013. Accordingly, the model will continue to include the dementia condition categories.

Greater Protection for Beneficiaries

- As authorized by the Affordable Care Act, to protect enrollees in MA plans from significant increases in costs or cuts in benefits from one year to the next, the amount of any permissible increase to total beneficiary costs is limited to \$34 per member per month for 2014 (down from \$36 per member per month in the previous year).
- To avoid unnecessary and unwanted prescriptions being delivered and charged to Medicare enrollees because of “auto-ship” services, Part D plans will require their network pharmacies to obtain enrollee consent prior to each delivery, unless the enrollee personally requests the refill. CMS strongly encourages Part D plans to implement this consent requirement for the remainder of this year.

Lower Out-of-Pocket Drug Spending

The deductible and out-of-pocket limit for the defined standard prescription drug (Part D) plan, will be lower in 2014, compared to 2013. Beneficiary costs will be further reduced as coverage for Medicare enrollees who have reached the prescription drug coverage gap, or “donut hole” continues to expand in 2014. As a result of the Affordable Care Act, in 2014, enrollees in the donut hole will receive coverage and discounts of 52.5 percent on covered brand name drugs and coverage of 28 percent on covered generic drugs. To date, 6.3 million beneficiaries have received savings of \$6.1 billion on prescription drugs.

Improved Coordination of Care

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In coordination with the Million Hearts initiative, plans are encouraged to improve access and adherence to anti-hypertensive medications by expanding their target enrollee populations for medication therapy management (MTM). Individuals who receive MTM may experience better blood pressure control, increased adherence to these vital medications, and better self-management of their medications and health condition.

The CMS press release announcing the Rate Announcement and Final Call Letter is available at: http://www.cms.gov/apps/media/press_releases.asp

The Rate Announcement, Final Call Letter and Ratebooks can be found using the following link: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>

Please contact the CMS Office of Legislation if you have any questions. Thank you.

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Sent: 16 Dec 2014 15:18:42 -0500
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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Releases Fourth Weekly Snapshot of Marketplace Open Enrollment Activity

U.S. House and Senate Notification
Tuesday, December 16, 2014

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Releases Fourth Weekly Snapshot of Marketplace Open Enrollment Activity

Today, CMS released the fourth weekly snapshot of Federal Marketplace Open Enrollment activity. Nearly 2.5 million consumers have selected plans since the beginning of Open Enrollment – more than one million of those selections coming in just the last week. As expected, consumer interest in health insurance coverage increased as we neared the December 15 enrollment deadline for January 1, 2015 coverage. This week's report does not include the final three days before December's deadline.

HHS will produce monthly reports that provide a detailed look at plan selection across the Federally Facilitated Marketplace and State-Based Marketplaces. In addition, CMS is releasing weekly snapshots of preliminary data. These snapshots do not include the consumers who visited, called, shopped or selected a plan through a State-Based Marketplace.

The weekly Open Enrollment snapshots for the Federally Facilitated Marketplace (FFM) provide point-in-time estimates for weekly data. These are preliminary numbers and could fluctuate based on consumers changing or canceling plans or having a change in status such as new job or

marriage. The snapshots also include totals from the beginning of Open Enrollment. Note that data revisions may mean that the weekly totals do not sum to the cumulative numbers.

Federal Marketplace Snapshot	Week 4	Cumulative
	Dec 6 – Dec 12	Nov 15 – Dec 12
Plan Selections	1,082,879	2,466,562
<i>New consumers</i>	47 percent	48 percent
<i>Consumers renewing coverage</i>	53 percent	52 percent
Applications Submitted	1,549,698	4,076,272
Call Center Volume	1,562,877	4,099,144
Average Call Center Wait Time	13 minutes 12 seconds	5 minutes 59 seconds
Calls with Spanish Speaking Representative	124,422	361,010
Average Wait for Spanish Speaking Rep	18 seconds	12 seconds
HealthCare.gov Users	3,742,146	10,882,935
CuidadoDeSalud.gov Users	117,289	348,760
Window Shopping HealthCare.gov Users	1,269,809	4,090,375
Window Shopping CuidadoDeSalud.gov Users	26,489	83,739

Consumers can shop and sign up for affordable health coverage that best fits their health and financial needs any time between now and February 15, 2015. Most consumers who previously had coverage through the Marketplace and did not take action before the December 15 deadline will be automatically re-enrolled into their current plan or a plan with similar benefits.

A fact sheet with additional information can be found here:

<http://www.hhs.gov/healthcare/facts/blog/2014/12/open-enrollment-week-four.html>

Please contact the CMS Office of Legislation if you have any questions. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 12 Sep 2011 15:08:24 -0400
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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Releases Guidance on the State Balancing Incentives Payment Program
Attachments: SMDL 11 010.pdf, Final BIPP Application.pdf

U.S. House and Senate Notification
Monday, September 12, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Releases Guidance on the State Balancing Incentives Payment Program

Today, the Centers for Medicare & Medicaid Services (CMS) released a State Medicaid Director letter providing guidance to States on the implementation of Section 10202 of the Affordable Care Act, which establishes the "State Balancing Incentive Payments Program."

Effective October 1, 2011, the Balancing Incentive Payments Program provides a strong financial incentive to stimulate greater access to non-institutionally based Medicaid long-term services and supports (LTSS). This provision will assist States in transforming their long-term care systems by improving systems performance and efficiency, creating tools to facilitate person-centered assessment and care-planning, as well as enhancing quality measurement and oversight. In addition, the Balancing Incentive Program provides new opportunities to serve more individuals in home and community-based settings, adding to the available tools for realization of the integration directive included in the Americans with Disabilities Act (ADA), as upheld by the *Olmstead* Supreme Court decision.

The attached letter provides a high-level overview of the Balancing Incentive Payments Program, along with the required structural changes and timeframes for implementation. As described in more detail in an accompanying application, the funding authorized in Section 10202 of the Affordable Care Act will provide an increased Federal Medical Assistance Percentage (FMAP) payment to States participating in the Balancing Incentive Program for non-institutional LTSS and will be made available as a non-competitive grant to States.

The enhanced FMAP matching payments are tied to the percentage of a State's non-institutional LTSS spending, with lower FMAP increases going to States with a less significant need for reforms. Total funding over the four-year period (October 1, 2011 – September 30, 2015) cannot exceed \$3 billion in Federal increased matching payments. This letter and the accompanying application serve as a notice of this funding opportunity.

For your convenience, a copy of the SMD letter and accompanying application are attached. All SMD letters may be found on the CMS website at <http://www.cms.gov/SMDL/SMD/list.asp> and this SMD will be available at this website within the next week.

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP and Survey & Certification

SMDL# 11-010
ACA# 20

Dear State Medicaid Director:

This letter provides guidance to States on the implementation of Section 10202 of the Affordable Care Act, which establishes the “State Balancing Incentive Payments Program,” hereafter referred to as the Balancing Incentive Program.

The Balancing Incentive Program provides a strong financial incentive to stimulate greater access to non-institutionally based long-term services and supports (LTSS). This provision will assist States in transforming their long-term care systems by improving systems performance and efficiency, creating tools to facilitate person-centered assessment and care-planning, as well as enhancing quality measurement and oversight. In addition, the Balancing Incentive Program provides new opportunities to serve more individuals in home and community-based settings, adding to the available tools for realization of the integration directive included in the Americans with Disabilities Act (ADA), as upheld by the *Olmstead* decision.

This letter provides a high-level overview of the Balancing Incentive Program, along with the required structural changes and timeframes for implementation. As described in more detail in the accompanying application, the funding authorized in Section 10202 of the Affordable Care Act will provide an increased Federal Medical Assistance Percentage (FMAP) payment to States participating in the Balancing Incentive Program for non-institutional LTSS and will be made available as a non-competitive grant to States. This letter and the accompanying application serve as a notice of this funding opportunity. All questions regarding this opportunity, as well as all application materials, should be sent to BalancingIncentiveProgram@cms.hhs.gov.

Background

Effective October 1, 2011, the Balancing Incentive Program offers a targeted increase in the FMAP for non-institutional LTSS to States that undertake structural reforms to increase access to non-institutional LTSS. The enhanced matching payments are tied to the percentage of a State’s non-institutional LTSS spending, with lower FMAP increases going to States with a less significant need for reforms. Total funding over the four-year period (October 1, 2011 – September 30, 2015) cannot exceed \$3 billion in Federal increased matching payments.

Implementation of Structural Changes

As part of the Balancing Incentive Program application, the State agrees to make the following structural changes:

1. A No Wrong Door–Single Entry Point system (NWD/SEP);
2. Conflict-free case management services; and
3. A core standardized assessment instrument.

States must provide a letter of commitment to make the required structural changes and submit a work plan for the implementation of the structural changes within six months from the date of application submission. The draft work plan must demonstrate that the structural changes will be in effect no later than September 30, 2015 and that States will meet the statutory rebalancing spending targets.

This opportunity aligns with other provisions and activities that move toward the development and implementation of these important structural changes. CMS will work with States to help accomplish these changes. CMS will monitor compliance with the structural changes required under the program and agreed to under the State work plan. Failure to meet required changes under the work plan will result in loss of the Balancing Incentive Program increased FMAP.

Detailed information about the classification of long-term services and supports for the purposes of determining States' eligibility and the required structural changes can be found in the accompanying application.

We hope the guidance set forth in the application increases the likelihood of States' participation in this exciting opportunity to support balancing the States' long-term services and supports system. We look forward to working with States, individually and collectively, to provide assistance and to facilitate collaboration in implementing this new grant program. CMS would like to reiterate that this option is but one tool among many in current law and Affordable Care Act that States can use to improve service delivery for all people, not just those with chronic conditions or those covered by Medicaid.

Please send any comments or questions to BalancingIncentiveProgram@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Center for Medicaid, CHIP, and Survey & Certification

**Patient Protection and Affordable Care Act
Section 10202
State Balancing Incentive Payments Program**

Initial Announcement

CFDA 93.543

OMB Control No: 0938-1145, Expiration Date: 03/31/2012

Applicable Dates:

Grant Period of Performance: October 1, 2011 – September 30, 2015

Applications for participation in the Balancing Incentive Payments Program will be accepted on an ongoing basis beginning [insert revised date] through August 1, 2014, or until the full provision of the \$3 billion has been projected to be expended, whichever date is earlier.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-New. The time required to complete this application is estimated to average 40 hours per response, including the time to review instructions and complete/submit the State Medicaid Agency Cover Letter; Project Abstract; Letters of Agreement, Endorsements and Support; Application Narrative; Preliminary Work Plan; Proposed Budget (using the Informational Financial Reporting Form in Attachment B); and the Final Work Plan. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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- Attachment A– Application Submission Checklist
- Attachment B– Informational Financial Form
- Attachment C– Percentage of LTSS Spending for HCBS Using FFY 2009 Data

I. FUNDING OPPORTUNITY DESCRIPTION

1. Background: Need and Opportunity

Section 10202 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (The Affordable Care Act), entitled the “State Balancing Incentive Payments Program,” hereafter referred to as the Balancing Incentive Program, authorizes additional Federal funds to States to provide financial incentives to increase access to non-institutionally based long-term services and supports (LTSS).

Effective October 1, 2011, the Balancing Incentive Program offers a targeted increase in the Federal Medical Assistance Percentage (FMAP) to States that undertake structural reforms to increase access to non-institutional LTSS. The increased matching payments are tied to the percentage of a State’s non-institutional LTSS spending, with lower FMAP increases going to States that need to make fewer reforms. The Balancing Incentive Program provides increased FMAP to States in return for their implementation of structural changes, including a No Wrong Door/Single Entry Point System (NWD/SEP), conflict-free case management services, and a core standardized assessment instrument. Total funding over the four-year period (October 2011 – September 2015) cannot exceed \$3 billion in Federal increased matching payments.

Historically, some States have been successful at rebalancing their long-term care systems toward community-based care. The Balancing Incentive Program targets those States that need assistance starting up their rebalancing initiatives, offering support in the form of increased FMAP.

States can qualify for a five percentage point increase in FMAP through Balancing Incentive Program if less than twenty-five percent of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS, and by submitting an application that meets the programmatic requirements and structural reforms specified in the authorizing legislation (Section 10202 of the Affordable Care Act). These States must achieve a benchmark of twenty-five percent of total Medicaid expenditures on home and community-based LTSS, and complete the structural reforms, no later than September 30, 2015.

Additionally, States can qualify for receiving a two percentage point increase in FMAP through Balancing Incentive Program if less than fifty percent of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS, and by submitting an application that meets the Balancing Incentive Program provision’s programmatic requirements and structural reforms. These States must achieve a benchmark of fifty percent of total Medicaid expenditures on home and community-based LTSS, and complete the required structural reforms, no later than September 30, 2015.

In both cases, as specified in Section 10202(c) of the Affordable Care Act, States may not restrict eligibility for LTSS more than eligibility standards, methodologies, or procedures in place as of December 31, 2010.

Over the last several decades, the Social Security Act (the Act) has been amended several times to help reduce the institutional bias in Medicaid long-term care. These amendments have given States increasing authority to create community-based systems of care and still receive Federal financial participation (FFP) for the home and community-based services (HCBS) they provide. Under Section 1915(c) of the Act, States can ask the Secretary of Health and Human Services (HHS) – via the Centers for Medicare & Medicaid Services (CMS) – to waive certain statutory requirements of the SSA, including the requirement to provide the same services to everyone who is eligible based on their needs and income ("comparability") and the requirement to provide the same services throughout the State ("statewideness"). Under Section 1915(i), States can amend their Medicaid plans to provide HCBS based on needs-based criteria, rather than diagnosis, and to individuals whose needs do not necessarily rise to institutional level of care. Under Section 1915(j), States can amend their plans to give individuals the power to self-direct their personal assistance services (PAS). Finally, under Section 1115, States can create demonstration programs to deliver community-based care in innovative ways.

In addition to the Balancing Incentive Program, the Affordable Care Act established new authorities for providing Medicaid-funded HCBS and support the balancing of LTSS. These new authorities include the Community First Choice Option, a State Plan option to provide HCBS, which provides an increased FMAP of 6 percentage points for program costs, and a Health Homes State plan option to coordinate care for individuals with chronic conditions, and receive 90 percent FMAP for health home services for the first 8 fiscal quarters. The Affordable Care Act also amended existing authorities that complement the Balancing Incentive Program and support the growth of HCBS. These include the extension of the Money Follows the Person demonstration program and the Aging and Disability Resource Center program.

2. Grant Program Requirements

The Balancing Incentive Program provides that participating State grantees make important structural changes to qualify for the increased Federal match, including the development of a No Wrong Door/Single Entry Point System (NWD/SEP), Conflict-free Case Management, and the development and use of a Core Standardized Assessment Instrument, and must submit a detailed budget (outlined later) that specifies how States plan to expand non-institutional LTSS to achieve their rebalancing targets. Grantees must create a statewide system of LTSS that ensures that: all individuals have the same access to information and resources on LTSS, regardless of their first point of entry into the system; individuals are assessed once for the entire range of LTSS for which they may be eligible; and that the eligibility determination and enrollment process proceeds in a streamlined manner, with the functional and financial components of eligibility coordinated. An important part of a NWD/SEP system is that individuals are assessed for the entire range of services and programs for which they might be eligible only once using a single instrument – a Core Standardized Assessment Instrument. By facilitating access to LTSS, the Balancing Incentive Program aims to reduce institutionalization and improve access to care.

States must submit a preliminary work plan at the time of application that describes in detail the plans for achieving the requirements of the Balancing Incentive Program within the program period. States must commit to produce a final work plan within six months from the date of application submission. The State must also submit a proposed budget that details the State's

plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports during the balancing incentive period and achieve the target spending percentage applicable to the State.

A. Implementation of Structural Changes

As part of this application, the State agrees to make the following structural changes:

1. A No Wrong Door/Single Entry Point system (NWD/SEP);
2. Conflict-free case management services; and
3. A core standardized assessment instrument.

CMS strongly urges States to use this opportunity to think strategically about implementation of other provisions in the Affordable Care Act that require these structural changes or a variation thereof. Several of these provisions are discussed in more detail beginning on page 14 of this document.

CMS supported an environmental scan of opportunities and challenges to the implementation of a NWD/SEP and utilization of core standardized assessment instruments. This information informs this application and a subsequent Balancing Incentive Program user manual. The user manual will be made available to all States in September 2011.

As part of the application process, States will be expected to provide a letter of commitment to make structural changes and to submit a work plan for the implementation of the structural changes within six months from the date of application submission. The draft work plan must demonstrate that the structural changes will be in affect no later than September 30, 2015.

In addition to the structural changes, States are encouraged to consider other structural changes, such as optional presumptive eligibility, which are outside of those required in the legislation but can be used as tools to help the State achieve the target spending percentages.

Structural Changes Required

A. No Wrong Door/Single Entry Point System

A key component of the structural changes promoted by the Balancing Incentive Program is development of a “No Wrong Door/Single Entry Point System” (NWD/SEP) for long-term care services and supports. A NWD/SEP requires the development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral(s) for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

A Statewide System:

A NWD/SEP ensures that individuals accessing the system experience the same process and receive the same information about LTSS options wherever they enter the system. After entering the system, the needs assessment and eligibility determination process proceeds smoothly, with

designated NWD/SEP agencies guiding the individual through the entire process from eligibility determination to enrollment in services.

LTSS Information & Initial Assessment:

An important component of a Balancing Incentive Program NWD/SEP system is that it is a statewide system. A true statewide system ensures that individuals can access the system from any location within the State, and assures all individuals accessing the system experience the same process and receive the same information about LTSS options. To be statewide, a NWD/SEP system must include the following three components, which make up the key entry points to the system:

- 1) A set of designated Single Entry Point (SEP) agencies
- 2) An informative website about LTSS options in the State
- 3) A statewide 1-800 number that connects individuals to the SEP agencies or their partners

The three components of a NWD/SEP system are also the entry points through which an individual may enter the system.

A set of designated Single Entry Point (SEP) agencies form the core of the “no wrong door” system in each State. The Medicaid Agency is the lead SEP agency. Other participating agencies might include agencies such as: Area Agencies on Aging, Aging and Disability Resource Centers, and Centers for Independent Living. The SEP agencies have physical locations where individuals can inquire about LTSS, and receive initial and comprehensive eligibility assessments and determinations for Medicaid-funded LTSS. The SEPs design and disseminate standardized processes for information and referral and eligibility assessments for LTSS to all participating SEP agencies, ensuring a consistent experience for individuals seeking information and assistance.

An informative website about LTSS options in the State is another important component of a statewide NWD/SEP system. The content of the NWD/SEP website must be overseen by the lead SEP agency and must contain, at a minimum, basic information about the range of LTSS services available in the State and must list the statewide NWD/SEP 1-800 number and provide contact information for local SEP offices by county. The State must ensure that the NWD/SEP website is accessible to individuals with disabilities and compliant with Section 508 of the Rehabilitation Act of 1973.

A recent CMS statewide inventory determined that almost all States currently make available an informational website for potential LTSS applicants, and over one quarter of States currently have initial assessments online. Nearly all of these assessments are part of a general self-assessment tool which allows individuals to conduct initial eligibility checking for a host of medical and social public programs within the State (e.g., the Children’s Health Insurance Program, Temporary Assistance for Needy Families). Tools tend to result in a list of programs for which the individual may be eligible; a list of agencies and contact information are provided. In some cases results are tailored for the county where an applicant lives and a few systems let an applicant download the list of recommended agencies or convert it into a printer-friendly format. Additionally, a few States provide a mechanism for individuals to create a log in and save their

data, with the option to pass the data forward to the appropriate agency for the next step in the assessment process.

Even a simple self-evaluation is a valuable component of a NWD/SEP system. Self-assessments can be an important tool for informing consumers about the range of services for which they might be eligible. These systems also provide a way for individuals to make initial inquiries about services casually and outside of business hours. CMS encourages States to consider incorporating an online self-assessment into their NWD/SEP system, and ideally one that allows data to be passed forward to the SEP agency.

A 1-800 number is another important component of a NWD/SEP system, especially for individuals who are more comfortable talking to a “real person” rather than searching extensively for information on a website or for those individuals who do not have internet access. Toll-free numbers can also provide the ability to create a person to person hand off. For example, a consumer may call an 800 number, receive an initial screening of needs and eligibility for LTSS, and an appointment may be made over the phone for the next step in a needs assessment or application process. Toll-free numbers should also provide a web link to information and referral services for those with internet access and provide translation services for non-English speaking individuals. A recent environmental scan found that, while the majority of States do operate an 800 number that can provide callers with general information about LTSS options, few States indicated that callers could be screened for eligibility for such options. CMS encourages States to set up systems by which individuals are able to have an initial evaluation completed via the 800 number. Additionally, States must ensure that the toll-free number is accessible to participants with disabilities.

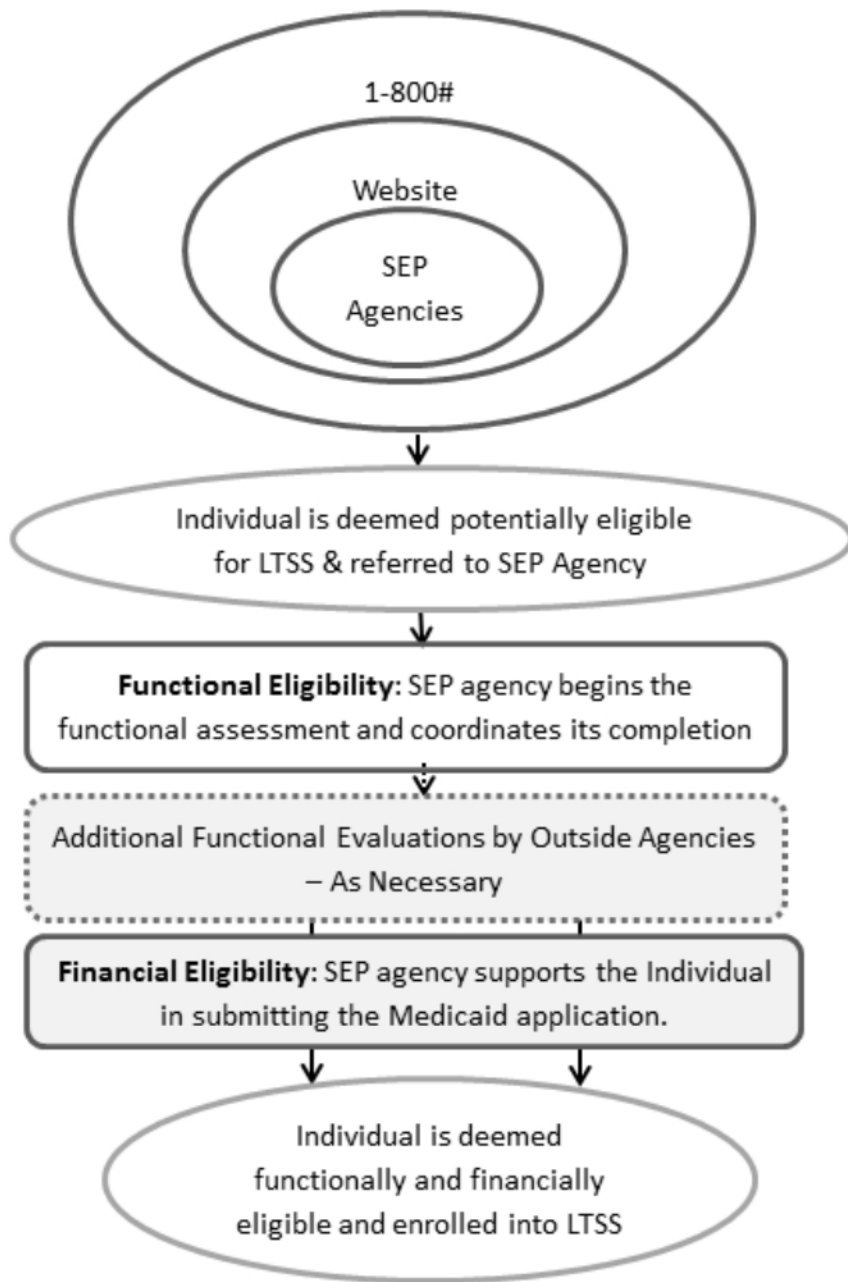
Together these three components form the basis of a statewide NWD/SEP system, allowing access to local services by phone, internet, and in person. More information regarding the physical proximity of individuals to SEP agencies is available below.

**Beneficiary is deemed potentially eligible for LTSS & referred to SEP Agency -
Beneficiary is assigned an eligibility coordinator at SEP Agency:**

In a NWD/SEP system, the SEP agency coordinates all components of the eligibility determination: both functional and financial, allowing individuals to receive streamlined eligibility determinations. SEP staff complete initial assessments and a comprehensive assessment. The same SEP agency also assists the individual to complete and submit the Medicaid financial application and any accompanying documentation, following the process through to eligibility determination. After determinations are made, SEP agencies help individuals choose among programs for which they are eligible, enroll in services, and apply eligibility decisions when appeals are requested by individuals. Ideally, under a NWD/SEP system one person – an eligibility coordinator – takes ownership of the complete eligibility determination process for an individual, providing the individual a single point of contact within the SEP agency.

States should consider co-locating functional and financial eligibility determination staff, as this will help expedite eligibility determinations.

The basic concept of how a person moves through a NWD/SEP system is illustrated by the following diagram, which presents the “person flow” through a NWD/SEP system. CMS expects that States will create a NWD/SEP system that reflects the person flow concept and expands it.



Data Considerations

In addition to considering the “person flow” of a NWD/SEP system, States will need to consider the “data flow” of such a system; that is the path data take from the point of initial collection of financial or functional information through to the final eligibility determination. There are many ways a State can structure data flow within a NWD/SEP system, and a robust NWD/SEP system considers data systems on many levels.

At the point of entry into the NWD/SEP system, the following are just a few questions States must consider: what information to include on the NWD/SEP website, how to keep this information up to date, whether to build an initial self-assessment tool into the website, and whether to create an option to save and transmit initial assessment data to NWD/SEP agencies. In cases where States maintain websites with comprehensive information about local LTSS resources, the SEP agency must keep this information up to date.

Coordination of financial and functional data is a key component of a NWD/SEP system and another important data consideration. All functional assessment data collected via the Core Standardized Assessment must be stored in a central location by the State Medicaid Agency. States will need to determine how the financial data required to determine eligibility for Medicaid LTSS will be handled. If financial data are processed in a separate system from the functional assessment data, the State will have to create a way to allow SEP staff to access both types of data – or the eligibility determinations based on both data sets – in order to make eligibility determinations. It is important that the SEP agency staff be apprised of the status of the financial eligibility determination and that data be processed quickly, and the results shared quickly as well. Ideally, States have systems in which financial and functional data systems are integrated or “talk to each other,” and the SEP agency staff are able to both input data into these systems and extract data necessary for making eligibility determinations.

Access to & Advertising for the NWD/SEP System

States should consider how true statewide access to the NWD/SEP system will be achieved. While the NWD website and 1-800 number will provide statewide access to LTSS information and to SEP agencies, individuals in each State will need to have local access to physical SEP agencies – or partners - in order to complete the full Core Standardized Assessment (CSA)/functional assessment. States must consider how SEPs are distributed relative to individuals likely to need them for evaluations and determinations. In the ideal situation, all individuals needing to interact with an SEP agency would be able to travel there and return home within a single day, accompanied or alone, by private or by public transportation. Individuals who can travel to a given SEP are considered to be in its service area. Individuals who cannot travel to a given SEP fall outside its service area. States must consider how individuals with disabilities and older adults will access the local SEP agency, including how access can be made available to individuals needing public transportation.

For a NWD/SEP system to be truly statewide, a large share of a State’s population should live within the service area of at least one SEP. CMS recognizes, however, that individuals living in rural areas may not fall within the service area of any SEPs. For this share of the population, the State should consider making other arrangements, such as contracting with home health agencies to make visits, either in-home or at a central location (such as a nearby hospital).

States should also plan to advertise their NWD/SEP system. The SEP agencies should become known as the “go to” agencies for LTSS. Advertisements and educational materials about the system must be made available in a variety of formats in order to be accessible to people of all disabilities, and must be made available to individuals in locations throughout the State.

Timeliness of Eligibility Determinations

If States are to truly balance their LTSS systems from institutional to community-based care, the timeliness of LTSS eligibility determinations must be improved. Often, people inquire about LTSS when they have an acute need for supports with activities of daily living (ADLs). In these cases, individuals need assistance immediately and cannot wait for a lengthy eligibility determination process to be completed before receiving services. For a variety of reasons, institutions are often more willing to admit individuals and provide services immediately. CMS encourages States to propose innovative methods for improving efficiencies in the eligibility determination process for LTSS.

B. Conflict-Free Case Management Services

States that participate in the Balancing Incentive Program will develop, as part of their NWD/SEP system, conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

For purposes of Balancing Incentive Program, States will establish conflict of interest standards for the independent evaluation and independent assessment. In this section, we refer to persons or entities responsible for the independent evaluation, independent assessment, and the plan of care as “agents” to distinguish them from “providers” of home and community-based services.

The design of services, rate establishment, payment methodologies, and methods of administration by the State Medicaid agency may all contribute to potential conflicts of interest. These contributing factors can include obvious conflicts such as incentives for either over- or under-utilization of services; subtle problems such as interest in retaining the individual as a client rather than promoting independence; or issues that focus on the convenience of the agent or service provider rather than being person-centered. Many of these conflicts of interest may not be deliberate decisions on the part of individuals or entities responsible for the provisions of service; rather, in many cases they are outgrowths of inherent incentives or disincentives built into the system that may or may not promote the interests of the individual receiving services.

To mitigate any explicit or implicit conflicts of interest, the independent agent should not be influenced by variations in available funding, either locally or from the State. The plan of care must offer each individual all of the LTSS that are covered by the State that the individual qualifies for, and that are demonstrated to be necessary through the evaluation and assessment process. The plan of care must be based only on medical necessity (for example, needs-based criteria), not on available funding. Conflict-free case management prohibits certain types of referrals for services when there is a financial relationship between the referring entity and the

provider of services. Payment to the independent agent for evaluation and assessment, or qualifications to be an independent agent, cannot be based on the cost of the resulting care plans.

We are aware that in certain areas there may only be one provider available to serve as both the agent performing independent assessments and developing plans of care, and the provider of one or more of the LTSS. To address this potential problem, the State may permit providers in some cases to serve as both agent and provider of services, but with guarantees of independence of function within the provider entity. In certain circumstances, CMS may require that States develop "firewall" policies, for example, separating staff that perform assessments and develop plans of care from those that provide any of the services in the plan (and ensuring that the evaluations of that staff are not based on the cost of the care plan); and meaningful and accessible procedures for individuals and representatives to appeal to the State. States should not implement policies to circumvent these requirements by suppressing enrollment of any qualified and willing provider.

CMS recognizes that the development of appropriate plans of care often requires the inclusion of individuals with expertise in the provision of long-term services and supports or the delivery of acute care medical services. As discussed previously, this is not intended to prevent providers from participating in these functions, but to ensure that an independent agent retains the final responsibility for the evaluation, assessment, and plan of care functions.

The State must ensure the independence of persons performing evaluations, assessments, and plans of care. Written conflict-free case management ensures, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual,
- related by blood or marriage to any paid caregiver of the individual,
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual,
- providers of State plan LTSS for the individual, or those who have interest in or are employed by a provider of State plan LTSS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement).*

C. Core Standardized Assessment Instruments

States participating in Balancing Incentive Program will develop core standardized assessment (CSA) instruments for determining eligibility for non-institutionally-based long-term services and supports, which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and to develop an individual service plan to address such needs.

There are two major benefits of adopting a CSA for statewide use. First, because CSAs focus on an individual's need for assistance with ADLs and instrumental activities of daily living

(IADLs), the evaluation is focused on an individual's true needs, rather than on their current or potential diagnoses; in other words, a CSA promotes a person-centered approach to needs assessment. Second, a CSA used statewide will provide States with a true picture of the needs of all individuals seeking LTSS in their State. A dataset comprised of CSA data for all LTSS consumers can help States with future budget and services planning. CSA data can also be used to help States prioritize individuals with the highest need in cases where services have wait lists. Finally, CSAs may be used to develop individualized budgets for self-directed consumers.

CMS expects that the CSA will be developed under the leadership of the designated lead NWD/SEP agency in each State and that each SEP agency will have staff trained to administer the CSA. The CSA should provide the minimum dataset for eligibility for Medicaid-funded LTSS.

In practice, CMS anticipates that States will implement a CSA that involves two parts: an initial evaluation and a comprehensive evaluation. Not everyone who enters the NWD/SEP system will be an appropriate candidate for a complete CSA evaluation. In other words, not everyone who walks in the door of a NWD/SEP agency, or otherwise inquires about LTSS services (e.g. via phone or website) will be a likely candidate for these services. Therefore, individuals making initial inquiries about LTSS will go through an initial assessment to determine whether a full CSA is warranted.

The initial assessment will point to potential needs and program eligibility, and may be conducted over the phone or in person by trained designated agency staff, or completed as a self-assessment online. If an individual "tests positive" for LTSS needs on the initial evaluation, they may complete the full CSA evaluation. The CSA provides a more complete picture of an individual's abilities and needs and must be completed in person by trained designated agency staff.

D. Advantages to Participating States

Technical Assistance to States

CMS will provide a User Manual to all States in September, 2011. The Manual will provide guidance to State grantees on implementing Balancing Incentive Program, including materials such as: example case studies of person flow and data flow in a NWD/SEP system, presentation of varied models for data sharing in a NWD/SEP system, guidance for selecting a vendor or an internal team to develop or administer NWD/SEP data systems, guidance on developing the Balancing Incentive Program work plan, and a checklist for grantees to evaluate their planned NWD/SEP system against the Balancing Incentive Program criteria.

CMS is also creating a prototype CSA, which may be adopted by grantees. The prototype CSA will be provided to grantees upon award. Grantees that do not wish to adopt the prototype CSA will have the option to use an alternate CSA, provided it collects a core set of data elements. The core set of data elements will likely contain data items in the following categories: demographic information and current enrollment in programs such as Medicare and Social Security Income (SSI), ADLs, IADLs, known medical conditions, and problem behaviors. The final core data set will be provided to grantees in the Manual. The Manual will also include guidance on cross-

walking an alternate CSA to the core set of data elements under the Balancing Incentive Program.

Streamlined Eligibility & Enrollment Requirements

Streamlining and simplifying eligibility and enrollment into Medicaid is an important focus of the Affordable Care Act. By 2014, States will upgrade their eligibility systems to process Medicaid enrollment using a simplified eligibility determination process for most non-aged, non-disabled beneficiaries, as well as support integrated eligibility determination among insurance affordability programs. We encourage States to consider the relationship between their Affordable Care Act-related system changes, and how they plan to accommodate eligibility verification and enrollment (including functional and financial eligibility) for LTSS programs.

Funding Available for Development & Implementation of NWD/SEP System & CSA

Because the increased Federal matching dollars under the Balancing Incentive Program can only be used to cover services, States will need to utilize other funding sources to cover the costs of the structural changes required to participate in the Balancing Incentive Program. Various provisions of the Affordable Care Act align with the goals of the Balancing Incentive Program; in some cases where goals and requirements overlap, funding for these initiatives may be used to cover the Balancing Incentive Program activities. The following potential funding sources may be sources for funding NWD/SEP system development. Additional guidance on the potential use of these funds to support the Balancing Incentive Program infrastructure development will be forthcoming.

- **Medicaid Management Information Systems (MMIS):** On April 19, 2011, CMS released a final rule titled “Medicaid: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities.” The rule increases the Federal matching rate for Medicaid eligibility and enrollment system development from 50 percent to 90 percent through December 2015, contingent on States meeting certain conditions and standards. The rule explicitly expanded the definition of Medicaid Management Information Systems (MMIS) activities to include eligibility determinations (eligibility determinations had previously been explicitly excluded from MMIS functions eligible for enhanced Federal Financial Participation (FFP)). The final rule can be found at <http://edocket.access.gpo.gov/2011/pdf/2011-9340.pdf>.

In order to be eligible for the enhanced MMIS match, States must meet certain standards and requirements applicable to both claims management and eligibility and enrollment procedures within MMIS. For example, both the eligibility system and the MMIS will need to process claims, communicate with providers, beneficiaries, and the public, produce transaction data and reports, and ensure coordination between Medicaid, CHIP and the Exchanges. In addition, States must build a MMIS infrastructure based on the Medicaid Information Technology Architecture (MITA) standards. A key goal of MITA is to modernize State Medicaid systems, with a focus on streamlining and simplifying enrollment, and moving away from sub-system components toward a Service Oriented Architecture. States should consider how to incorporate functional assessment, financial eligibility processing, enrollment, and key data sharing for LTSS into their transformed MMIS. It is important to note that these enrollment and eligibility systems must be in compliance with Section 504 of the Americans with Disabilities Act (ADA), which requires that individuals

with disabilities have an equal opportunity to benefit from Federally-funded programs, including those using electronic and information technology. More information about the standards and requirements are available at the link above.

- **Money Follows the Person (MFP):** Money Follows the Person was established by the Deficit Reduction Act of 2005, with a goal of helping States to balance their long-term care systems and help Medicaid enrollees transition from institutions to the community. Section 2403 of the Affordable Care Act extended the MFP Demonstration Program through 2016 and appropriated an additional \$2.25 billion to the program; \$450 million for each fiscal year during 2012-2016. The new funding is to strengthen existing Demonstration Programs, and for additional States to participate. Currently, 43 States and the District of Columbia participate in MFP and have been awarded \$2,095,172,282 for program efforts through 2016.

MFP funding provides increased FMAP for HCBS received by individuals transitioned from an institution into the community. As stated in the MFP application, “The increased FMAP funding, as well as significant financial resources to support the administration of the demonstration are available for the implementation of broader infrastructure investments. These investments include initiatives such as...building “no wrong door” access to care systems.”¹

- **Aging and Disability Resource Centers Funding (ADRC):** ADRC funding, administered by the Administration on Aging (AoA), is one potential source of funding for the structural changes promoted by the Balancing Incentive Program. While the Balancing Incentive Program mission differs from the ADRC mission in some key ways, some components of the ADRC mission align with the NWD/SEP component of the Balancing Incentive Program. For example, ADRCs are to serve as “a visible and trusted source of information on the full range of long-term care options, including both institutional and home and community-based care, which are available in the community.” They are to provide a single point of entry to all publicly funded LTSS, including Medicaid. ADRCs are expected to perform consumer intake and screening, needs assessment, development of service plans, and both functional and financial eligibility.²

In partnership with the State Unit on Aging and other ADRC operating agencies, States should be able to make a fairly straightforward case for using ADRC funding to support development of a truly statewide comprehensive NWD/SEP system under the Balancing Incentive Program, which enables consumers streamlined access to all long-term services and supports. Additionally, using ADRC funds to support development of a CSA would be supporting the ADRC mission to conduct intake, screening, and needs assessment based on both financial and functional eligibility. Using a single CSA statewide would support the

¹ Center for Medicare and Medicaid Services. (July 26, 2010). Initial Announcement. Invitation to Apply for 2011. Money Follows the Person Rebalancing Grant Demonstration. Funding Opportunity Number: CMS-111-11-001. CFDA 93.791. Retrieved January 28, 2011. <https://www.cms.gov/CommunityServices/Downloads/MFP2011SolicitationFinalJuly29RH.pdf>

² O’Shaughnessy, Carol V. (November 19, 2010). Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-Term Services and Supports Maze. National Health Policy Forum. The George Washington University.

ADRC being a true single point of entry to all LTSS in the State. ADRCs may be “users” of or partners within the NWD/SEP system under Balancing Incentive Program, and supporting the Balancing Incentive Program can help ADRCs move toward the ideal of a statewide system of access to LTSS.

In 2010, HHS dedicated \$60 million through the Affordable Care Act to “help people navigate their health and long-term care options” (Department of Health and Human Services, 2010). ADRCs are among the entities eligible for this funding, with a section of the legislation (Section 2405) specifically dedicating \$10,000,000 each FY between 2010 and 2014 to ADRCs. In particular, recent ADRC funding has focused on options counseling standards to support the functions of intake, assessment, action plan development and follow-up through ADRCs, in turn improving ADRCs’ activities with regard to the Money Follows the Person initiative, and to coordinate with State Medicaid programs to help individuals leave nursing homes for community care (Department of Health and Human Services, 2010). Additional guidance on the potential use of these funds as well as others to support the Balancing Incentive Program infrastructure development will be forthcoming.

- **Other Administration on Aging (AoA) Funding:** The AoA also provides ongoing formula grants for the general implementation of their mission. Many of these grants complement and support the functions within a NWD/SEP system, even if the grants do not specifically mention ADRC (Administration on Aging website <http://www.aoa.gov/AoARoot/Grants/Funding/>).

3. Number of Grant Awards

CMS will accept only one application from each State Medicaid Agency interested in participating in the Balancing Incentive Program. CMS expects that the Medicaid agency to partner with other State agencies; however the State Medicaid agency must be the lead applicant.

The number of grant awards approved by CMS depends on the scope (i.e., proposed enrollment and scope of services) and quality of the proposed programs; however, CMS anticipates the funding level to be sufficient to support approximately 20-25 States with up to \$3 billion dollars over the life of the program.

4. Grant Program Duration and Scope

Applications for participation in the Balancing Incentive Payments Program opportunity will be accepted on an ongoing basis beginning September 1, 2011 through August 1, 2014, or until the full provision of the \$3 billion has been expended, whichever date is sooner. Funding will be awarded for the Federal Fiscal Year beginning October 1, 2011. Continued funding will be awarded on an annual basis to all participating States, contingent upon progress, through September 30, 2015, or until the full \$3 billion has been expended. To receive continued funding in subsequent years (every 12 months), grantees will be awarded through a non-competitive process contingent upon the progress of the State towards meeting the benchmarks set forth in the State’s Work Plan and detailed in the Terms and Conditions.

5. Grant Program Technical Elements

A. State Eligibility Requirements

A Balancing Incentive Program State is a State in which less than fifty percent of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS and which submits an application that meets the programmatic requirements and structural reforms dictated by the authorizing legislation (Section 10202 of the Affordable Care Act). Specifically, States in which 25-50 percent of the total expenditures for medical assistance under the State Medicaid program are for non-institutionally-based LTSS are eligible for a two percentage point FMAP increase. States in which less than twenty-five percent of total expenditures are for non-institutionally based LTSS are eligible for five percentage point FMAP increase.

Eligible States receiving two percentage point increase in FMAP must achieve benchmarks of fifty percent of total LTSS expenditures under the State Medicaid program for non-institutionally based LTSS, while eligible States receiving five percentage point increase in FMAP must achieve benchmarks of twenty-five percent of total LTSS expenditures under the State Medicaid program for non-institutionally based LTSS, no later than September 30, 2015. The Balancing Incentive Program State must agree to use the increased FMAP only for purposes of providing new or expanded offerings of home and community-based LTSS. States must also commit to implement key structural reforms including a no NWD/SEP system, conflict-free case management services, and a core standardized assessment instrument. Finally, the State may not restrict eligibility for LTSS more than eligibility standards, methodologies, or procedures in place as of December 31, 2010.

Conditions for Receiving Increased FMAP under the Balancing Incentive Program: In order to receive the increased FMAP for services provided to Balancing Incentive Program-participating States, grantees must demonstrate ongoing progress toward developing a statewide NWD/SEP system utilizing a CSA, and progress toward implementing conflict-free case management. Progress will be measured by each grantee meeting the milestones specified in their Work Plan; the progress towards the achievement of these milestones will be reported to CMS through a semi-annual reporting process. CMS will provide, via the Balancing Incentive Program User Manual, a set of core milestones to grantees for incorporation into the Balancing Incentive Program Work Plan. Milestones may include, but are not limited to, the following example milestones:

- Development of MOUs with SEP agencies
- Development of protocol for information & referral
- Development of a training plan for staff administering the CSA
- Identification & training of individuals to administer CSAs
- Securing a vendor or identifying an in-house group to develop the State CSA database
- Identifying provider or services agencies to serve as potential partners to administer the CSA for local individuals in areas far from a SEP agency location.

B. Defining Long-Term Services and Supports

The classification of LTSS is important for several aspects of Balancing Incentive Program implementation: determining State eligibility for Balancing Incentive Program participation; establishing the appropriate services for increased FMAP; and service reporting dictated by the authorizing legislation.

State Eligibility for Program Participation: During CMS deliberations to determine the service classifications to establish State eligibility for the Balancing Incentive Program, several issues were considered, including: State variation in service definitions for LTSS, LTSS that are provided in institutional and non-institutional settings, variation within and across States in claiming for LTSS by funding authority, and the quality and timeliness of key LTSS program and expenditure data. Using available data sources, CMS established a high-level classification of institutional and non-institutional LTSS (as defined below) to establish State eligibility for the Balancing Incentive Program. A presumptive summary of State expenditures based on data available to CMS, and Balancing Incentive Program eligibility based upon this classification, is in the Attachment C of this application.

States may provide more detailed information than included in Attachment C regarding total Medicaid expenditures for institutional and non-institutional LTSS for fiscal year 2009 for purposes of determining Balancing Incentive Program eligibility. Further, States may possess more detailed information than available on the national level and are therefore encouraged to do so. Additional data submitted by States for eligibility purposes is subject to verification by CMS. CMS will review submitted financial data and service classifications for meeting eligibility on a State by State basis. Please note, State eligibility is based on total Medicaid expenditures for LTSS and may not be based on expenditures by target populations. However, please be advised that during the Balancing Incentive Program application and implementation period, we intend to work with eligible States to establish a more robust service categorization and reporting structure.

LTSS Eligible for the Balancing Incentive Program Increased FMAP:

The applicable percentage point increase is two percent for non-institutionally-based LTSS in States in which 25-50 percent of the total expenditures for medical assistance under the State Medicaid program are for non-institutionally-based LTSS and five percentage point increase in FMAP for non-institutionally-based LTSS in States in which less than twenty-five percent of total expenditures are for non-institutionally based LTSS. The increased FMAP under Balancing Incentive Program does not apply to the FMAP determined under Section 1905(y) of the Social Security Act for newly eligible mandatory individuals.

However, CMS acknowledges that data limitations using the eligibility methodology proposed above do exist. For example, the program authorities listed below where non-institutionally-based services may actually afford services provided in institutional settings. In order to meet the legislative intent of the Balancing Incentive Program and progress beyond existing measurement limitations, CMS will work with each State to establish a mechanism to expand the Balancing Incentive Program service classification and determine how State-specific services and encounters will be mapped to the Balancing Incentive Program service classifications.

The States' claiming process for the base FMAP for LTSS will not change; those services will continue to be reported on the traditional Form CMS 64. During the Balancing Incentive Program implementation period, CMS will partner with the Balancing Incentive Program grantees to improve the quality and timeliness of data for CMS, and to make national Medicaid data more readily available to States and other stakeholders. We expect to see an evolution in the service categorization that will enrich the national portrayal of LTSS.

Balancing Incentive Program Service Categorization

Institutionally-Based Services: For purposes of Balancing Incentive Program eligibility, CMS defines institutionally-based Medicaid LTSS as services provided in:

- Nursing facilities;
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR);
- Institutions for Mental Diseases (IMD) for people under age 21 or age 65 or older;
- Long-term care hospitals as defined for the Medicare program (i.e., those with an average length of stay of 25 or more days); and
- Psychiatric hospitals that are not IMDs.

Non-institutionally-Based Services: CMS defines non-institutionally-based Medicaid LTSS as services provided only in integrated settings that are home and community-based and therefore not provided in the institutions defined above. Non-institutionally based LTSS are provided under the following Medicaid program authorities:

- HCBS under 1915 (c) or (d) or under an 1115 Waiver;
- Home health care services;
- Personal care services;
- PACE;
- Home and community care services defined under Section 1929(a); and
- LTSS provided under managed long-term care programs authorized under Sections 1915(a) or 1915(b), including programs that do not have a co-occurring 1915(c) waiver.

There are several LTSS that were not included in the initial Balancing Incentive Program eligibility calculation due to the lack of available or sufficient data, or limited program implementation. These include, but are not limited to, State plan rehabilitation services authorized under 1905(a)(13), self-directed personal assistance services in 1915 (j), services provided under 1915(i), private duty nursing authorized under Section 1905 (a)(8) (provided in home and community-based settings only), services that may be offered under new program authorities authorized by the Affordable Care Act (Community First Choice, Health Homes, etc.). CMS will work with interested States to collect the data necessary to include other LTSS in determining each States' service eligibility for the Balancing Incentive Program increased FMAP.

C. Reporting Requirements

Work Plan: Upon application, States will submit a preliminary Work Plan. Within six months of the date of application submission, each grantee must submit a Finalized Work Plan describing in detail how the NWD/SEP utilizing a CSA and conflict-free case management will be operationalized in the State during the four year Balancing Incentive Program period. The Work

Plan must be developed by the SEP Agencies in consultation with key stakeholders. The Work Plan should include a detailed operational plan and budget for all years, which describe how the grantee plans to develop the NWD/SEP system, develop and implement use of a CSA, and what funding sources the grantee plans to utilize to develop the system. The budget should include details of the grantee's plan to expand and diversify services for non-institutional LTSS and achieve the applicable targeted spending percentage for these services, and projections of estimated LTSS expenditures through the end of the performance period. This Work Plan must also describe measurable milestones to be achieved throughout the performance period. As previously stated, CMS will provide a Work Plan template to Balancing Incentive Program grantees within the Balancing Incentive Program User Manual.

Balancing Incentive Program Reporting Requirements: The Balancing Incentive Program provision (Affordable Care Act Section 10202) describes key data to be reported under the program. Each grantee will submit an annual Data Report and Programmatic Progress Report. The Balancing Incentive Program Data Report must include data that will delineate the grantee's current standing concerning meeting the milestones specified in their Work Plan. Progress Reports will be measured based on implementing core milestones necessary to successfully implement the program prior to the end of the grant period. These include: services data from providers of non-institutional LTSS, quality data that are linked to population-specific outcomes measures and accessible to providers, and specific outcomes measures to be collected and submitted that measure beneficiary and family caregiver experience and satisfaction with providers and services. Data will also be collected on employment, participation in community life, health stability, and prevention of loss in function. During the Balancing Incentive Program implementation period, CMS will work with grantees to finalize data specifications and procedures for the approved services, quality, and outcomes measures specified in the legislation. However, if a grantee consistently and materially fails to demonstrate satisfactory progress in reaching their milestones, it will be asked to submit a Corrective Action Plan. Failure to carry out their Corrective Action Plan may result in suspension or termination for non-compliance.

All grantees will submit services data from providers of non-institutional LTSS, quality data linked to population-specific outcomes, and outcomes measures data as directed by CMS and required by the Balancing Incentive Program legislation. Data will be submitted to CMS via the reporting platform designated by CMS. Upon award, CMS will work in consultation with grantees to develop and finalize all aspects of data reporting requirements and procedures.

The quality measures are derived from: Medicaid Adult Health Quality Measures: a subset, to be determined, of the identified core set of health care quality measures as determined in the Final rule for Section 2701 of the Affordable Care Act; Medicaid Experience of Care Measures: a subset, to be determined, of the HCBS experience of care measures (Consumer Assessment of Healthcare Providers and Systems, or CAHPS); and Functional Assessment Elements Measures: a subset, TBD, of functional assessment information collected by States in their HCBS programs.

The Balancing Incentive Program grantees will not be required to submit any quality data until the beginning of calendar year (CY) 2012. Data reporting and submission requirements will be phased in, that is, after CMS completes the development of data specifications, conducts

Plan must be developed by the SEP Agencies in consultation with key stakeholders. The Work Plan should include a detailed operational plan and budget for all years, which describe how the grantee plans to develop the NWD/SEP system, develop and implement use of a CSA, and what funding sources the grantee plans to utilize to develop the system. The budget should include details of the grantee's plan to expand and diversify services for non-institutional LTSS and achieve the applicable targeted spending percentage for these services, and projections of estimated LTSS expenditures through the end of the performance period. This Work Plan must also describe measurable milestones to be achieved throughout the performance period. As previously stated, CMS will provide a Work Plan template to Balancing Incentive Program grantees within the Balancing Incentive Program User Manual.

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The quality measures are derived from: Medicaid Adult Health Quality Measures: a subset, to be determined, of the identified core set of health care quality measures as determined in the Final rule for Section 2701 of the Affordable Care Act; Medicaid Experience of Care Measures: a subset, to be determined, of the HCBS experience of care measures (Consumer Assessment of Healthcare Providers and Systems, or CAHPS); and Functional Assessment Elements Measures: a subset, TBD, of functional assessment information collected by States in their HCBS programs.

The Balancing Incentive Program grantees will not be required to submit any quality data until the beginning of calendar year (CY) 2012. Data reporting and submission requirements will be phased in, that is, after CMS completes the development of data specifications, conducts

necessary training, and provides guidance for the collection of data at the State and Provider level for each of the major areas of data listed above.

D. Services and Financial Reporting

All Balancing Incentive Program State grantees will submit the financial reporting form on an annual basis (see Attachment B). This form will provide projected and actual LTSS expenditures. It will allow the State and CMS to track expenditures associated with the demonstration participants. Grantees will provide CMS with their current FMAP rate, eligible increased Balancing Incentive Program percentage, and service codes used that map to those services. They will also project the cost of their LTSS services for each budget period.

II. AWARD INFORMATION

1. Amount of Funding

Section 10202 of the Affordable Care Act includes an appropriation for \$3 billion. The amount of funding for each grant approved by CMS depends on the scope (i.e., proposed enrollment and scope of services) and quality of the proposed programs; however, CMS anticipates the funding level to support between 20-25 States with \$3 billion over the life of the program.

2. Period of Performance

The grant period-of-performance begins upon application approval. Increased FMAP is available beginning October 1, 2011 through September 30, 2015.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Applicants must be any single State Medicaid Agency. Only one application can be submitted for a given State. The term “State Medicaid program” means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

The CMS expects that the single State Medicaid Agency will partner with local governments, other agencies, and service providers who contribute to successful public health preventive initiatives in the State.

Applicants are strongly encouraged to include, in an appendix, letters of support indicating a history of collaboration from major partners, including consumers and advocacy groups. These

letters and memorandums of agreement should critique and substantiate the applicant's readiness to implement the structural changes.

2. Eligibility - Threshold Criteria

Applications for participation in the Balancing Incentive Payments Program opportunity will be accepted on an ongoing basis beginning [insert revised date] through August 1, 2014 or until the full provision of the \$3 billion has been projected to be expended, whichever date is earlier. However, an application will not be funded if the application fails to meet any of the requirements as outlined in Section III., Eligibility Information, and Section IV., Application Submission Information.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Submission of Application and Materials

Applicants must submit their applications via email to Balancing-Incentive-Program@cms.hhs.gov.

2. Content and Form of Application Submission

Form of Application Submission

i. Cover Letter

A letter from the State Medicaid Director identifying the Medicaid agency applicant as the lead organization, indicating the title of the project, the Principal Investigator, contact person, amount of funding requested, and the name of the agency that will administer the grant under the Medicaid office and all major partners, departments, divisions, services, and organizations actively collaborating in the project is required. This letter should be addressed to:

Jennifer Burnett
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-14-26
Baltimore, MD 21244-1850

ii. Project Abstract and Profile (maximum of one page)

The one-page abstract should serve as a succinct description of the proposed project and should include a summary of the overall project, the total budget, the State's plan for increasing the percentage of Medicaid LTSS dollars spent on community-based care, and a preliminary

timeline for completing the structural changes promoted by the Balancing Incentive Program.

iii. Preliminary Work Plan

Each State must submit a Preliminary Work Plan describing in detail how the NWD/SEP system, utilizing a CSA and conflict-free case management will be operationalized in the State during the four year Balancing Incentive Program period. The Work Plan must be developed by the SEP Agencies in consultation with key stakeholders. The Work Plan should include a detailed operational plan and budget for all years (see budget details below), which describe how the State plans to develop the NWD/SEP system, develop and implement the use of a CSA, and what funding sources the State plans to utilize to develop the system. The budget should include State projections of estimated LTSS expenditures through the end of the performance period. This Work Plan must also describe measurable milestones to be achieved throughout the performance period. A Finalized Work Plan will be due to CMS within six months of the date of application.

iv. Required Letters of Endorsement

Letters of endorsement from major partners that are not the lead agency, but will be integrally involved in developing and implementing the demonstration grant to the target population(s), are expected. Please submit all letters in support and memoranda/letters of agreement for your application in an application appendix with a table of contents for all included documents.

v. Application Narrative

The application is expected to address how the State will implement the grant program, and ultimately, meet the requirements of Section 10202 of the Affordable Care Act for the Balancing Incentive Payments Program.

The required elements (sections) of the application are listed below. Also, provided is a brief description of the type of information that is required to be addressed within each specific section. The application must be organized by these headings, noted as the operational element sections, outlined below.

In general, CMS is looking for initial plans for NWD/SEP systems, conflict-free case management, and implementation of Core Standardized Assessments in the application. CMS expects States to provide more detailed plans for each component of the NWD/SEP system in the Work Plan due six months after application. CMS will provide States with additional guidance on Balancing Incentive Program standards prior to the Work Plan deadline, including but not limited to the Balancing Incentive Program User Manual.

Required Elements

a. Understanding of Balancing Incentive Program Objectives: The State has demonstrated an understanding of and a commitment to the goals of the Balancing Incentive Program, and the concepts of a true NWD/SEP system for LTSS.

b. Current System's Strengths and Challenges: The State has provided a description of the

existing LTSS information and referral, eligibility determination, and case management processes in the State.

c. NWD/SEP Agency Partners and Roles: The State has described the designated agencies that will likely comprise the SEP Agencies and has described each agency's anticipated role in the NWD/SEP system.

d. NWD/SEP Person Flow: The State has provided an initial description of the planned "person flow" through the NWD/SEP system (i.e., the experience of the eligibility determination process from an individual's perspective, from start to finish), including how the State plans to coordinate functional and financial eligibility within the eligibility determination process and how these processes differ from the current system.

e. NWD/SEP Data Flow: The State has provided a discussion of the "data flow" within the eligibility determination process and has described where functional and financial assessment data will be housed and how they will be accessed by SEP Agencies to make eligibility determinations.

f. Potential Automation of Initial Assessment: The State has described potential opportunities for and challenges of automating the initial assessment tool via the NWD/SEP website.

g. Potential Automation of CSA: The State has described potential opportunities for and challenges of automating a CSA/functional assessment tool. Automation includes, at a minimum, real time electronic collection of functional assessment data.

h. Incorporation of a CSA in the Eligibility Determination Process: The State has described the current functional assessment instruments and processes used to determine eligibility for LTSS. Does the State currently use a single CSA for all LTSS populations? If not, how might the State incorporate a CSA into its current process? What would be the major challenges to adopting a CSA? What technical assistance might the State need to make this happen?

i. Staff Qualifications and Training: The State has discussed considerations related to staff qualifications and training for administering the functional assessment.

j. Location of SEP Agencies: The State has provided a discussion of the issue of access to physical SEP agency locations. How will the State ensure access to physical SEP agency locations? What share of the State's population is likely to live within the service area of at least one SEP? (Rough estimates are acceptable.) What will the State do to maximize the share of the State's population living within the service area of at least one SEP? How will the State arrange evaluation services for individuals who do not live within the service area of any SEPs? How will the State ensure that these physical locations are accessible by older adults and individuals with disabilities requiring public transportation?

k. Outreach and Advertising: The State has described plans for advertising the NWD/SEP system.

l. Funding Plan: The State has provided a discussion of anticipated funding sources to support the requirements of Balancing Incentive Program, including development of a NWD/SEP system and use of CSA.

m. Challenges: The State has provided a discussion of the characteristics of the State's current system of LTSS that might present barriers to rebalancing.

n. NWD/SEP's Effect on Rebalancing: The State has discussed how the NWD/SEP system will help the State achieve rebalancing goals.

o. Other Balancing Initiatives: The State has described other current initiatives in which it is currently involved that share similar goals and requirements as the Balancing Incentive Program. The State has described any more general commitment made toward rebalancing LTSS.

p. Technical Assistance: The State has described anticipated technical assistance needs to achieve rebalancing.

vi. Proposed Budget

The applicant must submit a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports during the balancing incentive period and achieve the target spending percentage applicable to the State. The budget should include the funding sources for the establishment of the structural changes and a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services.

3. Submission Dates and Times

A. Applicant's Teleconference

Information regarding the date, time and call-in number for an open applicants' teleconference will be e-mailed to all State Medicaid Directors.

B. Grant Applications

Applications for participation in the Balancing Incentive Payments Program opportunity will be accepted on an ongoing basis beginning [insert revised date] through August 1, 2014 or until the full provision of the \$3 billion has been expended, whichever is earlier.

C. Late Applications

Late applications will not be reviewed.

D. Grant Awards Timeframe

Grants are planned to be awarded within 60 days of application.

4. Funding Restrictions

All funds awarded under the Balancing Incentive Program are for non-institutionally-based long-term services and supports only for the balancing incentive period.

5. Review and Selection Process

CMS has the authority to approve or deny any or all proposals for funding that do not meet the programmatic requirements of this funding opportunity.

VI. AWARD ADMINISTRATION INFORMATION

Award Notices

Successful applicants will receive an award letter will set forth the amount of the award and other pertinent information. The award will also include Terms and Conditions, and may also include additional “special” terms and conditions. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the review panel.

A. Prohibited Uses of Grant Funds:

Balancing Incentive Program Grant funds may not be used for any of the following:

1. To match any other Federal funds.
2. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
3. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries for programs and purposes other than those disclosed in the application for the Balancing Incentive Program, etc.

VII. AGENCY CONTACTS

Programmatic Content

Questions about the Balancing Incentive Program should be addressed to Balancing-Incentive-Program@cms.hhs.gov or to

Effie R. George, Ph.D.
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-14-26
Baltimore, MD 21244-1850
Effie.George@cms.hhs.gov

VIII. ENFORCEMENT ACTIONS

A grantee's failure to comply with the terms and conditions of award may cause CMS to take one or more of the following enforcement actions, depending on the severity and duration of the non-compliance. CMS will undertake any such action in accordance with applicable statutes, regulations, and policies. CMS will afford the grantee an opportunity to correct the deficiencies before taking enforcement action. However, even if a grantee is taking corrective action, CMS may take proactive steps to protect the Federal government's interests, including placing special conditions on awards or precluding the grantee from obtaining future awards for a specified period, or may take action designed to prevent future non-compliance, such as closer monitoring.

1. Modification of the Terms and Conditions of Award

During grant performance, CMS may include special conditions in the award to require correction of identified financial or administrative deficiencies. When the special conditions are imposed, CMS will notify the grantee of the nature of the conditions, the reason why they are being imposed, the type of corrective action needed, the time allowed for completing corrective actions, and the method for requesting reconsideration of the conditions. (See 45 CFR 92.12.)

CMS may also withdraw approval of the Project Director (PD) or other key personnel if there is a reasonable basis to conclude that they are no longer qualified or competent to perform. In that case, CMS may request that the recipient designate a new PD or other key personnel. The decision to modify the terms of an award—by imposing special conditions, by withdrawing approval of the PD or other key personnel, or otherwise—is discretionary on the part of CMS.

2. Suspension or Termination

If a grantee has failed to materially comply with the terms and conditions of award or to demonstrate satisfactory progress in reaching their milestones, CMS may suspend the award or temporarily or permanently stop the payment of increased FMAP, pending corrective action, or may terminate the grant for cause. The regulatory procedures that pertain to suspension and termination are specified in 45 CFR 92.43. CMS generally will suspend (rather than immediately terminate) an award and allow the recipient an opportunity to take appropriate

corrective action before making a termination decision. CMS may decide to terminate the grant if the grantee does not take appropriate corrective action during the period of suspension.

CMS may terminate—without first suspending—the award if the deficiency is so serious as to warrant immediate termination. Termination for cause may be appealed under the HHS grant appeals procedures.

An award also may be terminated, partially or totally, by the grantee or by CMS with the consent of the grantee. If the grantee decides to terminate a portion of a grant, CMS may determine that the remaining portion of the award will not accomplish the purposes for which the award was originally awarded. In any such case, the grantee will be advised of the possibility of termination of the entire award and will be allowed to withdraw its termination request. If the grantee does not withdraw its request for partial termination, CMS may initiate procedures to terminate the entire award for cause.

Attachment A – Application Submission Checklist

- _____ State Medicaid Agency Cover Letter
- _____ Project Abstract
- _____ Letters of Agreement, Endorsements and Support
- _____ Application Narrative
- _____ Preliminary Work Plan
- _____ Proposed Budget (using the Informational Financial Reporting Form in Attachment B)

Please see Section IV *Required Contents* for detailed information on the application submission requirements.

The final work plan is due to CMS no later than six months from date of application.

Attachment B

**DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
BALANCING INCENTIVE PAYMENTS PROGRAM (Balancing Incentive Program) APPLICANT FUNDING ESTIMATES
LONG TERM SERVICES AND SUPPORTS**

State					State FMAP Rate				
Agency Name					Extra Balancing Incentive Program Portion (2 or 5 %)				
Quarter Ended									
Year of Service (1-4)									
					Projected LTSS Spending				
LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2	Year 3	Year 4	
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	
Case Management									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Homemaker									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Homemaker Basic									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Homemaker Chore services									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Home Health Aide									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Personal Care									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Personal care ADLs									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Personal Care IADLs									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					

LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2	Year 3	Year 4
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Personal Care Health-related								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Personal Care Adult Companion								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Personal Care PERS								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Pers. Care Assistive Technology								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Habilitation Day								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Habilitation Behavioral								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Habilitation Prevocational								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Hab. Supported Employment								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Hab. Educational Services								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Respite Care								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Day Treatment / Partial Hosp.								
Service 1	\$0	\$0	\$0	\$0				

Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				

LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2	Year 3	Year 4
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Psychosocial Rehabilitation								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Clinic Services								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Other HCBS Services								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
<i>(Add row for each service as named in approval letter)</i>								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Capitated HCBS Services ²								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Health Homes								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
CFC								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
TOTALS	\$0	\$0	\$0	\$0				
CMS MOD-Balancing Incentive Program DEMO 64i Application Form								

Attachment C

Percentage of LTSS Spending for HCBS Using FFY 2009 Data

LTSS is defined as Services Listed in the ACA, Section 10202(f)(1)* and Mental Health Facilities (including DSH). Data includes estimated expenditures for managed care (MC) long-term services and supports from FFY 2009.

Number of States Below 50%: 38

Number of States Below 25%: 1

Number of States At or Above 50%: 13

State	Nursing Facility FFS	ICF/MR FFS	MC NF and ICF/MR**	MH Facilities - Regular	MH Facilities - DSH	Total Institutional	HCBS FFS	MC HCBS**	HCBS	Percent HCBS
New Mexico	\$59,720,513	\$24,014,829	\$71,050,749	\$5,029,475	\$254,786	\$160,070,352	\$419,908,376	\$373,016,434	\$792,924,810	83.2%
Oregon	\$341,814,529	\$7,098,075		\$3,775,444	\$14,981,318	\$367,669,366	\$958,979,907		\$958,979,907	72.3%
Minnesota	\$835,049,290	\$176,405,610	\$35,987,316	\$53,639,400	\$82,060	\$1,101,163,676	\$2,164,351,802	\$166,714,270	\$2,331,066,072	67.9%
Arizona	\$33,119,468	\$0	\$442,609,336	\$1,443,268	\$28,474,900	\$505,646,972	\$9,033,182	\$1,013,604,110	\$1,022,637,292	69.3%
Vermont	\$118,215,099	\$0	-\$403,252	\$0	\$0	\$117,811,847	\$56,856,875	\$161,076,254	\$217,933,129	64.9%
Alaska	\$118,855,368	\$1,454,971		\$16,628,109	\$13,357,682	\$150,296,130	\$252,561,562		\$252,561,562	62.7%
Washington	\$582,533,776	\$156,180,487		\$24,975,999	\$120,336,661	\$884,026,923	\$1,447,943,331		\$1,447,943,331	62.1%
Colorado	\$548,943,656	\$23,440,493		\$3,898,823	\$0	\$576,282,972	\$797,996,360		\$797,996,360	58.1%
California	\$3,945,503,021	\$634,412,454	\$450,379,907	\$254,170,718	\$0	\$5,284,466,100	\$6,517,886,786	\$0	\$6,517,886,786	55.2%
Kansas	\$375,257,360	\$66,104,633		\$15,527,519	\$22,749,884	\$479,639,396	\$579,383,292		\$579,383,292	54.7%
Wisconsin	\$1,098,776,448	\$283,288,787	\$72,914,961	\$30,161,950	\$3,945,475	\$1,489,087,621	\$873,203,370	\$746,572,981	\$1,619,776,351	52.1%
Wyoming	\$72,834,891	\$17,520,919		\$30,153,861	\$0	\$120,509,671	\$124,489,528		\$124,489,528	50.8%
Washington DC	\$197,295,629	\$73,766,501		\$9,945,625	\$2,093,737	\$283,101,492	\$286,662,072		\$286,662,072	50.3%
Maine	\$254,107,927	\$63,010,003		\$52,510,334	\$51,447,476	\$421,075,740	\$405,782,955		\$405,782,955	49.1%
Montana	\$158,289,932	\$12,147,430		\$16,075,461	\$0	\$186,512,823	\$166,786,079		\$166,786,079	47.2%
Texas***	\$2,151,950,372	\$898,706,862	\$55,895	\$23,932,285	\$292,457,483	\$3,367,102,897	\$2,584,970,257	\$390,390,523	\$2,975,360,780	46.9%
New York	\$7,618,853,959	\$3,112,018,238	\$56,394,896	\$504,603,782	\$347,100,000	\$11,638,970,875	\$9,506,953,405	\$683,578,809	\$10,190,532,214	46.7%
Idaho	\$157,450,986	\$55,032,345		\$14,643,485	\$0	\$227,126,816	\$194,964,284		\$194,964,284	46.2%
Rhode Island	\$294,059,457	\$11,424,484		\$5,342,942	\$1,578,394	\$312,405,277	\$265,920,855		\$265,920,855	46.0%
Massachusetts	\$1,616,521,340	\$265,098,972	\$159,660,054	\$144,913,316	\$0	\$2,186,193,682	\$1,739,056,166	\$35,157,317	\$1,774,213,483	44.8%
Connecticut	\$1,239,838,546	\$524,279,815		\$52,752,285	\$101,160,516	\$1,918,031,162	\$1,516,168,534		\$1,516,168,534	44.1%
Utah	\$149,490,224	\$60,964,653		\$16,351,840	\$89,866	\$226,896,583	\$177,905,204		\$177,905,204	43.9%
North Carolina	\$1,287,569,396	\$511,407,803		\$84,935,419	\$149,908,784	\$2,033,821,402	\$1,530,426,971		\$1,530,426,971	42.9%
Hawaii****	\$104,752,171	\$9,911,448	\$104,752,171	\$0	\$0	\$219,415,790	\$139,073,151	\$24,245,483	\$163,318,634	42.7%
Virginia	\$769,097,900	\$283,507,550		\$137,039,082	\$7,129,293	\$1,196,773,825	\$883,322,914		\$883,322,914	42.5%
Tennessee	\$975,022,948	\$267,567,506	\$0	\$1,214,388	\$349,231	\$1,244,154,073	\$674,182,772	\$242,356,000	\$916,538,772	42.4%
Nevada	\$162,315,188	\$16,426,532		\$41,944,771	\$0	\$220,686,491	\$157,082,327		\$157,082,327	41.6%
Oklahoma	\$529,503,379	\$126,206,862		\$99,920,358	\$3,273,248	\$758,903,847	\$539,127,664		\$539,127,664	41.5%
New Hampshire	\$314,619,705	\$3,252,472		\$4,600,087	\$34,392,417	\$356,864,681	\$249,996,686		\$249,996,686	41.2%
Missouri	\$870,160,260	\$152,896,442		\$44,112,202	\$198,763,354	\$1,265,932,258	\$870,174,316		\$870,174,316	40.7%
South Dakota	\$142,270,277	\$23,336,646		\$3,649,448	\$751,299	\$170,007,670	\$115,695,916		\$115,695,916	40.5%
West Virginia	\$459,260,145	\$64,027,039		\$49,589,094	\$18,873,019	\$591,749,297	\$394,606,696		\$394,606,696	40.0%
Iowa	\$460,741,103	\$305,373,772		\$39,657,577	\$0	\$805,772,452	\$532,145,157		\$532,145,157	39.8%
Nebraska	\$317,950,416	\$66,975,809		\$44,510,525	\$8,556,063	\$437,992,813	\$273,186,838		\$273,186,838	38.4%
South Carolina	\$513,252,844	\$166,524,666		\$56,661,502	\$52,761,795	\$789,200,807	\$491,575,117		\$491,575,117	38.4%
Georgia	\$1,149,417,503	\$79,700,951		\$21,566,400	\$0	\$1,250,684,854	\$748,012,573		\$748,012,573	37.4%

Percentage of LTSS Spending for HCBS Using FFY 2009 Data										
State	Nursing Facility FFS	ICF/MR FFS	MC NF and ICF/MR**	MH Facilities - Regular	MH Facilities - DSH	Total Institutional	HCBS FFS	MC HCBS**	HCBS	Percent HCBS
Maryland	\$1,061,474,895	\$44,205,359		\$192,620,414	\$50,547,776	\$1,348,848,444	\$784,496,744		\$784,496,744	36.8%
Louisiana	\$744,256,941	\$468,057,200		\$17,816,489	\$110,557,148	\$1,340,687,778	\$767,292,107		\$767,292,107	36.4%
Delaware	\$185,844,847	\$27,903,771		\$1,176,289	\$5,853,198	\$220,778,105	\$120,014,480		\$120,014,480	35.2%
Florida	\$2,402,791,045	\$328,017,908	\$12,157,471	\$14,415,216	\$112,437,431	\$2,869,819,071	\$1,507,068,472	-\$12,157,471	\$1,494,911,001	34.2%
Michigan	\$1,534,989,618	\$3,410,277		\$21,493,058	\$141,909,300	\$1,701,802,253	\$837,890,881		\$837,890,881	33.0%
Pennsylvania	\$3,605,567,586	\$617,822,886		\$75,580,478	\$241,000,002	\$4,539,970,952	\$2,234,687,629		\$2,234,687,629	33.0%
Ohio	\$2,561,349,803	\$686,875,994		\$409,575,379	\$93,432,758	\$3,751,233,934	\$1,803,755,463		\$1,803,755,463	32.5%
Kentucky	\$827,779,576	\$100,520,929		\$50,745,362	\$37,443,075	\$1,016,488,942	\$459,366,913		\$459,366,913	31.1%
Indiana	\$1,206,919,909	\$315,550,361		\$60,141,320	\$96,145,012	\$1,678,756,602	\$740,060,814		\$740,060,814	30.6%
Arkansas	\$572,795,228	\$144,399,452		\$142,810,938	\$0	\$860,005,618	\$365,276,497		\$365,276,497	29.8%
Alabama	\$938,113,372	\$37,940,939		\$60,947,000	\$3,301,620	\$1,040,302,931	\$438,806,576		\$438,806,576	29.7%
North Dakota	\$173,635,728	\$78,192,543		\$11,961,292	\$987,735	\$264,777,298	\$107,501,966		\$107,501,966	28.9%
Illinois	\$1,631,062,689	\$545,816,762		\$96,762,565	\$111,393,766	\$2,385,035,782	\$916,517,066		\$916,517,066	27.8%
New Jersey	\$1,943,333,776	\$664,713,723		\$155,568,662	\$506,221,035	\$3,269,837,196	\$1,146,377,769		\$1,146,377,769	26.0%
Mississippi	\$727,351,102	\$277,194,524		\$61,561,997	\$0	\$1,066,107,623	\$178,917,475		\$178,917,475	14.4%

* Data does not include expenditures authorized under 1915(d), 1915(i), and only includes some expenditures authorized under 1915(j). The CMS 64 database did not clearly identify 1915(i) and 1915(j) expenditures until 2010. No states use 1915(d).

** Managed long-term care are estimates for FFY 2009 based on data provided by state staff unless otherwise noted.

*** Texas managed care data are for SFY 2009, which is from September 2007 to August 2008.

*** Hawaii MLTC data are estimates developed by Thomson Reuters based on FFS expenditures reported during the first half of FFY 2009 for NF and HCBS for older adults and people with physical disabilities. Hawaii moved these services to managed care during FY 2009 and has not yet submitted MLTC estimates for FFY 2009. During FFY 2009, reported FFS expenditures were approximately half of expenditures for previous years.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 22 Dec 2015 15:47:54 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Palmer, Gary (Cari Kelly);Roby, Martha (Sophie Trainor);Sessions, Jeff (Emily_Mcbride@sessions.senate.gov);Sewell, Terri (Hillary Beard);Shelby, Richard (Dayne Cutrell);Bilirakis, Gus;Bilirakis, gus (Kristin Seum);Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Edward Kim);cesar.gonzalez@mail.house.gov;Clawson, Curt (Alyssa Wootton);Crenshaw, Ander (Catherine Skitsko);Curbelo, Carlos (Ashley Rose);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gram, Gwen (hill.thomas@mail.house.gov);Grayson, Alan (Racalto, Joe);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (Clarey Walker);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Kevin Ashley);Hastings, Alcee (Matthew Price);John Mica (Casey.Brinck@mail.house.gov);Jolly, Richard (Ian Manzano);Kobernat, Dolly (Bill Nelson);Malmgren, Corey (Bill Nelson);Mekhdjavakian, Taleen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Alyssa Wang);Nugent, Richard (Danielle Doheny);Posey, Bill (Anna Schartner);Posey, Bill (Kapavik, Christen);Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (Tim Cummings);Rubio, Marco (Eduardo Sacasa);Simon, David (Brown, Corine);Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Rachel Hall);Wasserman Schultz, Debbie (Roselyn Kumar);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Wilson, Frederica (Kyle Johnson);Allen, Rick (Hunter, Katie);Bartolomeo, Jordan (Isakson);Bishop, Sanford (jonathan.halpern@mail.house.gov);Carter, Buddy (chase.cannon@mail.house.gov);Collins, Doug (Jennifer Lackey);Collins, Doug (Katie Evans);David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov);David Scott (lauren.lattany@mail.house.gov);Eunice, John (Perdue);Graves, Tom (Bo Butler);Graves, Tom (Rebecca Anderson);Hice, Jody (Michael Calvo);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Lewis, John (Thomas Dorney);Loudermilk, Barry (Easton Randall);Perdue, David (Sarah Schatz);Price, Tom (Amanda Street);Price, Tom (Ashley Palmer);Price, Tom (DiBlasio, Carla);Scott, Austin (Beal, Mary Dee);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Barr, Andy (Francis Brooke);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);shannon.rickett@mail.house.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Allred, SarahLloyd (Wicker);Bennie Thompson (Cory Horton);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Nunnelee, Alan (Elliza Jones);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Anna Rush);'Thompson, Bennie';(Esther_Clark@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Alma (Margaret Franklin);Adams, Alma (Sandra Brown);Adams, Alma (Shaniqua McClendon);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Angela Boothe);Burr, Richard (Colin Rom);Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Dennis Sills);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Kristi Thompson);Holding, George (Jason Cooke);Hudson, Richard (Preston Bell);Jones, Walter (joshua.bowlen@mail.house.gov);'McHenry, Patrick';Meadows, Mark (Zach Enos);Pittenger, Robert

(Michelle Jelnicky);Price, David;Price, David (Nora Blalock);Rouzer, David (Kyle Sanders);Tillis, Thom (Matt Flynn);Tillis, Thom (Ray Starling);Virginia Foxx (Stringer, Meghan);Walker, Mark (Joel Heimbach);Clyburn, James (Ashli Palmer);Duncan, Jeff (Addie Carrie);Gowdy, Trey (Nicholas Spencer);Graham, Lindsey (Jessica Phillips-Tyson);Graham, Lindsey (Nick Myers);Mulvaney, Mick (Natalee Binkholder);Prianti, Marissa (L. Graham);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Claire Brandewie);Scott, Tim (Will Holloway);Wilson, Joe (Candace Rich);Alexander, Lamar (Meeks, Brett);Black, Diane (Katie Allen);Black, Diane (Toomey, Jon);Blackburn, Marsha (Karen Summar);Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (Randy Wadkins);Cooper, Jim (Ann Waller Curtis);Corker, Bob (Hayly Humphreys);OS Vaughn, Richard;Duncan, John Jr (Lauren James);Duncan, John Jr. (Caroline DeBerry);Eblen, Alex (Corker);Fincher, Steve (Corey Schrodtt);Fleischmann, Chuck (Conner Ingram);Lapinski, MarySumpter (HELP Committee);Osborn, Sarah (Corker);Phil Roe;Roe, Phil (John Martin);Tatgenhorst, James (Corker)
<James_Tatgenhorst@corker.senate.gov>

Cc: Saklas, Ariadne (CMS/OL);Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS Releases Quarterly Effectuated Enrollment Snapshot

U.S. House and Senate Notification
Tuesday, December 22, 2015

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Releases Quarterly Effectuated Enrollment Snapshot

Today, the Centers for Medicare and Medicaid Services (CMS) announced that on September 30, 2015, about 9.3 million consumers had effectuated Health Insurance Marketplace coverage – which means those individuals paid their premiums and had an active policy at the end of September. HHS's effectuated enrollment projection continues to be 9.1 million people for the end of 2015.

Of the approximately 9.3 million consumers nationwide with effectuated Marketplace enrollments at the end of September 2015, about 84 percent, or more than 7.8 million consumers, were receiving an advance payment of the premium tax credit (APTC) to make their premiums more affordable throughout the year. The average APTC for those enrollees who qualified for the financial assistance was \$271 per month.

There were 6.7 million consumers with effectuated enrollments at the end of September 2015 through the 37 Federally-Facilitated Marketplaces, including State Partnership Marketplaces and supported state-based Marketplaces that utilize the HealthCare.gov eligibility and enrollment platform (collectively known as HealthCare.gov states) and 2.6 million through the remaining State-based Marketplaces. Effectuated enrollment for the 37 states that use HealthCare.gov platform as of June 30, 2015 was 7.2 million, and 2.7 million for the remaining State-based Marketplaces.

CMS releases Marketplace state-by-state effectuated enrollment snapshots on a quarterly basis, detailing how many consumers have an effectuated enrollment, how many are benefiting from financial assistance, and the distribution of effectuated enrollment by qualified health plan metal level. Our September 30 effectuated total of 9.3 million is consistent with meeting our goal for 2015. Changes in effectuated enrollment are influenced by many factors and vary from quarter to quarter.

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

To view the effectuated enrollment snapshot, visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-22-2.html>.

If you have any questions, please contact the Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 22 Dec 2015 15:49:11 -0500
To: Howell, Cherie A. (CMS/OL);Rep. Young;Sen. Murkowski;Sen. Sullivan;Sen. Sullivan;Rep. Womack;Rep. Crawford;Rep. Crawford;Rep. Hill;Rep. Westerman;Sen. Boozman;Sen. Cotton (Brian_colas@cotton.senate.gov);Rep. Labrador (Aaron.calkins@mail.house.gov);Rep. Simpson;Sen. Crapo;Sen. Risch (Rachel_burkett@risch.senate.gov);Rep. Abraham;Rep. Boustany;Rep. Boustany;Rep. Fleming;Rep. Garret Graves;Rep. Graves;Rep. Richmond;Rep. Scalise;Sen. Cassidy;Sen. Vitter;Rep. Lujan;Rep. Lujan;Rep. Lujan;Rep. Lujan (Jeffery.bustamante@mail.house.gov);Rep. Lujan Grisham;Rep. Lujan Grisham;Rep. Pearce;Rep. Pearce (Patrick.cuff@mail.house.gov);Sen. Heinrich;Sen. Udall;Rep. Bridenstine (mark.piland@mail.house.gov);Rep. Cole;Rep. Lucas;Rep. Mullin (Adam.Buckalew@mail.house.gov);Rep. Russell;Sen. Inhofe;Sen. Lankford (Katherine_Mayne@lankford.senate.gov);Rep. Blumenauer;Rep. Bonamici;Rep. Bonamici;Rep. Defazio;Rep. DeFazio (kris.pratt@mail.house.gov);Rep. Schrader;Rep. Walden;Rep. Blumenauer;Sen. Merkley (Susan_Lexer@merkle.senate.gov);Sen. Wyden;Rep. O'Rourke;Rep. AL Green;Rep. Babin;Rep. Babin;Rep. Barton;Rep. Brady;Rep. Brady;Rep. Burgess;Rep. Castro;Rep. Conaway;Rep. Cuellar (Ryan.Ehly@mail.house.gov);Rep. Culberson;Rep. Culberson;Rep. Doggett;Rep. Doggett;Rep. Eddie Bernice Johnson;Rep. Farenthold;Rep. Flores;Rep. Gene Green;Rep. Gohmert;Rep. Granger;Rep. Hensarling;Rep. Hinojosa;Rep. Hurd;Rep. Jackson Lee;Rep. Marchant;Rep. McCaul;Rep. Neugebauer;Rep. Olson;Rep. Orourke;Rep. Poe;Rep. Ratcliffe;Rep. Sam Johnson;Rep. Sessions (elle.ross@mail.house.gov);Rep. Smith;Rep. Smith;Rep. Thornberry;Rep. Veasey (kenny.palmer@mail.house.gov);Rep. Vela (jasey.cardenas@mail.house.gov);Rep. Weber;Rep. Williams;Sen. Cornyn;Sen. Cornyn;Sen. Cruz;Rep. Adam Smith;Rep. DelBene;Rep. Heck;Rep. Heck;Rep. Heck;Rep. Heck;Rep. Herrera;Rep. Kilmer;Rep. Larsen (matt.renninger@mail.house.gov);Rep. McDermott;Rep. McMorris Rodgers;Rep. Newhouse;Rep. Reichert;Sen. Cantwell;Sen. Cantwell;Sen. Murray (madeleine_pannell@help.senate.gov)
Cc: Chadwick, Alpheus K. (CMS/OL);Saklas, Ariadne (CMS/OL)
Subject: Hill Notification: CMS Releases Quarterly Effectuated Enrollment Snapshot

U.S. House and Senate Notification

Tuesday, December 22, 2015

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: CMS Releases Quarterly Effectuated Enrollment Snapshot

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were receiving an advance payment of the premium tax credit (APTC) to make their premiums more affordable throughout the year. The average APTC for those enrollees who qualified for the financial assistance was \$271 per month.

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CMS releases Marketplace state-by-state effectuated enrollment snapshots on a quarterly basis, detailing how many consumers have an effectuated enrollment, how many are benefiting from financial assistance, and the distribution of effectuated enrollment by qualified health plan metal level. Our September 30 effectuated total of 9.3 million is consistent with meeting our goal for 2015. Changes in effectuated enrollment are influenced by many factors and vary from quarter to quarter.

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

To view the effectuated enrollment snapshot, visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-22-2.html>.

If you have any questions, please contact the Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 10 Dec 2014 14:29:19 -0500
To: Bucklen, Kim L. (CMS/CQISCO);CBC Staff;Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Manweiler, Kelsey (Shelby);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];Paul Winfree (Sessions/Budget);Sewell, Terri (Hillary Beard);Shelby, Richard (Jay Dunn);Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Al-Kourainy, Amir (Bill Nelson);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Katie Wise);Clawson, Curt (Jeff Post);Crenshaw, Ander;Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gittess, David (Bill Nelson);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (LaTasha Lee);Hastings, Alcee (Mike Sykes);Joe Garcia (Anna Gonzalez);John Mica (Casey.Brinck@mail.house.gov);Jolly, David (LJ Govoni);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Laura Cooper);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Eduardo Sacasa);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Dolan, Coby);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (Bobby McMillin);Collins, Doug (Jennifer Lackey);Collins, Doug (Vernon Robinson);David Scott (lauren.lattany@mail.house.gov);Graves, Tom (Bo Butler);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Marshall Thomas);'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Coulter, Margaret (HELP Committee));Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Gribble, Kristi);Ellmers, Renee (Mitchell Vakerics);Farrar, Elizabeth

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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Releases Third Weekly Snapshot of Marketplace Open Enrollment Activity

**U.S. House and Senate Notification
Wednesday, December 10, 2014**

To: Congressional Health Staff

**From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: CMS Releases Third Weekly Snapshot of Marketplace Open Enrollment Activity

Today, CMS released the third weekly snapshot of Federal Marketplace Open Enrollment activity. During open enrollment, HHS will produce a monthly report that provides a detailed look at plan selection across the Federally-Facilitated Marketplace and State-Based Marketplaces. In addition to the monthly report, CMS is releasing weekly snapshots of preliminary data. These snapshots do not include the consumers who visited, called, shopped or selected a plan through a State-Based Marketplace.

The weekly Open Enrollment snapshots for the Federally-Facilitated Marketplace (FFM) provide point-in-time estimates for weekly data. These are preliminary numbers that are subject to revision and fluctuate based on consumers changing or canceling plans or having a change in status such as new job or marriage. The snapshots also include totals from the beginning of Open Enrollment. Note that data revisions may mean that the weekly totals do not sum to the cumulative numbers.

Federal Marketplace Snapshot	Week 3	Cumulative
	Nov 29 – Dec 5	Nov 15 – Dec 5

Plan Selections	618,548	1,383,683
<i>New consumers</i>	48 percent	48 percent
<i>Consumers renewing coverage</i>	52 percent	52 percent
Applications Submitted	974,018	2,526,574
Call Center Volume	982,022	2,536,267
Average Call Center Wait Time	3 minutes 11 seconds	2 minutes 31 seconds
Calls with Spanish Speaking Representative	87,534	236,588
Average Wait for Spanish Speaking Rep	12 seconds	9 seconds
HealthCare.gov Users	3,023,301	7,942,195
CuidadoDeSalud.gov Users	98,336	244,016
Window Shopping HealthCare.gov Users	1,072,169	3,061,540
Window Shopping CuidadoDeSalud.gov Users	19,675	61,068

Consumers can shop and sign up for affordable health coverage that fits their health and financial needs any time between now and February 15, 2015. For coverage to start on January 1, 2015, consumers must enroll in a plan by December 15, 2014. Current consumers enrolled in coverage through the Marketplace for 2014 should come back, update their application and shop by December 15 because there could be a plan that better meets their needs and they could qualify for more financial help. Most consumers who do not take action before the deadline will be automatically enrolled by their insurance company into their current plan or a plan with similar benefits.

A fact sheet with additional information can be found here:

<http://www.hhs.gov/healthcare/facts/blog/2014/12/open-enrollment-week-three.html>

Please contact the CMS Office of Legislation if you have any questions. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Mar 2015 10:05:55 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Manweiler, Kelsey (Shelby);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Palmer, Gary (Cari Kelly);Paul Winfree (Sessions/Budget);Roby, Martha (Sophie Trainor);Sessions, Jeff (Emily_Mcbride@sessions.senate.gov);Sessions, Jeff (Kim Brown);Sewell, Terri (Hillary Beard);Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Al-Kourainy, Amir (Bill Nelson);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Katie Wise);Clawson, Curt (Jeff Post);Crenshaw, Ander (Catherine Skitsko);Curbelo, Carlos (Ashley Rose);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gittess, David (Bill Nelson);Gram, Gwen (hill.thomas@mail.house.gov);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (Clarey Walker);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (LaTasha Lee);Hastings, Alcee (Mike Sykes);John Mica (Casey.Brinck@mail.house.gov);Jolly, Richard (Ian Manzano);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nugent, Richard (Danielle Doheny);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (Tim Cummings);Rubio, Marco (Eduardo Sacasa);Simon, David (Brown, Corine);Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Dolan, Coby);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Bartolomeo, Jordan (Isakson);Bishop, Sanford (jonathan.halpern@mail.house.gov);Carter, Buddy (chase.cannon@mail.house.gov);Collins, Doug (Jennifer Lackey);Collins, Doug (Vernon Robinson);David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov);David Scott (lauren.lattany@mail.house.gov);Eunice, John (Perdue);Graves, Tom (Bo Butler);Graves, Tom (Rebecca Anderson);Hice, Jody (Michael Calvo);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Lewis, John (Thomas Dorney);Loudermilk, Barry (Easton Randall);Price, Tom (DiBlasio, Carla);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Barr, Andy (Francis Brooke);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);shannon.rickett@mail.house.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Allred, SarahLloyd (Wicker);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Anna Rush);'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Alma (Sandra Brown);Adams, Alma (Shaniqua McClendon);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Coulter, Margaret (HELP Committee));Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Gribble, Kristi);Ellmers, Renee (Mitchell Vakerics);Holding, George (Jason Cooke);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);'McHenry, Patrick';Meadows, Mark (Ansley Rhyne);Pittenger, Robert

(Michelle Jelnicky);Price, David;Rouzer, David (Kyle Sanders);Tillis, Thom (Katy Talento);Tillis, Thom (Ray Starling);Virginia Foxx (Stringer, Meghan);Walker, Mark (Joel Heimbach);'Clyburn, James';Duncan, Jeff (Hilary Ranieri);Gowdy, Trey (Nicholas Spencer);Graham, Lindsey (Jessica Phillips-Tyson);Graham, Lindsey (Nick Myers);Mulvaney, Mick (Natalee Binkholder);Prianti, Marissa (L. Graham);Rice, Tom (Brianna Hewett);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Catherine Phillips);Wilson, Joe (Claire Brandewie);Alexander, Lamar (Alicia_Hennie@help.senate.gov);Black, Diane (Ellen Mailin);Black, Diane (Toomey, Jon);Blackburn, Marsha (Karen Summar);Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (Brittany Hernandez);Cooper, Jim (Ann Waller Curtis);Cooper, Jim (Ashley Shelton);'Corker, Bob';OS Vaughn, Richard;DesJarlais, Scott (Richard Wilkins);Fincher, Stephen (Chris Davis);Fleishmann, Charles;Healy, Jenifer (Corker);John Duncan (patra.stephan@mail.house.gov);Lapinski, MarySumpter (HELP Committee);Phil Roe;Roe, Phil (John Martin);Tatgenhorst, James (Corker) <James_Tatgenhorst@corker.senate.gov>

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CORRECTION: Tax Special Enrollment Period March 15 – April 30, 2015

**U.S. House and Senate Notification
Monday, March 16, 2015**

To: Congressional Health Staff

**From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: Tax Special Enrollment Period March 15 through April 30, 2015.

Please note that the dates listed on Friday's notification were incorrect. The correct dates for the Tax Special Enrollment Period are March 15 – April 30, as noted below.

The special enrollment period (SEP) for individuals and families who did not have health coverage in 2014 and are subject to the fee or "shared responsibility payment" when they file their 2014 taxes in states that use the Federally-facilitated Marketplaces (FFMs) runs from Sunday, March 15, and runs through Thursday, April 30, 2015.

Those eligible for this special enrollment period live in states using the FFMs and:

- Currently are not enrolled in coverage through the FFM for 2015,
- Attest that when they filed their 2015 tax return they paid the fee for not having health coverage in 2014, and
- Attest that they first became aware of, or understood the implications of, the Shared Responsibility Payment after the end of open enrollment (February 15, 2015) in connection with preparing their 2014 taxes.

Consumers can visit HealthCare.gov or contact the Marketplace Call Center at 1-800-318-2596 to enroll.

Please contact the CMS Office of Legislation if you have any questions. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 31 Aug 2016 16:52:30 +0000
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Palmer, Gary (Cari Kelly);Roby, Martha (Sophie Trainor);Rogers, Mike (Haley Wilson);Sessions, Jeff (Emily_Mcbride@sessions.senate.gov);Sewell, Terri (Hillary Beard);Shelby, Richard (Dayne Cutrell);Bilirakis, Gus;Bilirakis, gus (Kristin Seum);Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Edward Kim);cesar.gonzalez@mail.house.gov;Clawson, Curt (Alyssa Wootton);Crenshaw, Ander (Catherine Skitsko);Curbelo, Carlos (Ashley Rose);DeSantis, Ron (Becca Brown);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Gram, Gwen (hill.thomas@mail.house.gov);Grayson, Alan (Racalto, Joe);Hastings, Alcee (Kevin Ashley);Hastings, Alcee (Larissa Ferrell);Hastings, Alcee (Matthew Price);John Mica (Casey.Brinck@mail.house.gov);Jolly, David (Ian Manzano);Kobernat, Dolly (Bill Nelson);Malmgren, Corey (Bill Nelson);Mekhdjavakian, Taleen (Bill Nelson);Mica, John (Brian Waldrip);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Alyssa Wang);Nugent, Richard (Danielle Doheny);Posey, Bill (Anna Schartner);Posey, Bill (Kapavik, Christen);Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (Tim Cummings);Rubio, Marco (Eduardo Sacasa);Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Rosalyn Kumar);Wasserman Schultz, Debbie (Sarah Arkin);Wasserman Schultz, Debbie (Sarah Farhadian);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Wilson, Frederica (Kyle Johnson);Allen, Rick (cameron.bishop@mail.house.gov);Allen, Rick (Hunter, Katie);Bartolomeo, Jordan (Isakson);Bishop, Sanford (jonathan.halpern@mail.house.gov);Carter, Buddy (chase.cannon@mail.house.gov);Collins, Doug (Jennifer Lackey);Collins, Doug (Katie Evans);David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov);David Scott (lauren.lattany@mail.house.gov);Eunice, John (Perdue);Graves, Tom (Bo Butler);Graves, Tom (Jason Murphy);Hice, Jody (Michael Calvo);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (Arya Hariharan);Lewis, John (Thomas Dorney);Loudermilk, Barry (Colin Carr);Loudermilk, Barry (Easton Randall);Price, Tom (Amanda Street);Price, Tom (Ashley Palmer);Price, Tom (DiBlasio, Carla);Scott, Austin (Beal, Mary Dee);Scott, David (Cramer, Martha);Westmoreland, Lynn (Porter, Amber);Woodall, Rob (Janet Rossi);Barr, Andy (Francis Brooke);Burkhalter, Natalie (Paul);Guthrie, Brett (Megan Jackson);Lewis, Katie (Paul);Massie, Thomas (Seana Cranston);'McConnell, Mitch';McConnell, Mitch (Natalie McIntyre);Paul, Rand (Bonnie Honaker);shannon.rickett@mail.house.gov;Whitfield, Ed (Cassie Leonard);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Allred, SarahLloyd (Wicker);Bennie Thompson (Cory Horton);Cochran, Thad (Elizabeth Joseph);Cochran, Thad (Mary Henson);Harper, Gregg (Jordan See);Henry, Elizabeth (Cochran);Kelly, Trent (Tara Gaddis);Palazzo, Steven (Patrick Large);'Thompson, Bennie';(Esther_Clark@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Alma (Margaret Franklin);Adams, Alma (Sandra Brown);Adams, Alma (Shaniqua McClendon);Blackburn, Marsha (Kristi Thompson);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Angela Boothe);Burr, Richard (Colin Rom);Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Dennis Sills);Butterfield, G.K. (Taylor, Annette);Holding, George (Jason Cooke);Hudson, Richard (Preston Bell);Jones, Walter (joshua.bowlen@mail.house.gov);'McHenry, Patrick';Meadows, Mark (Zach Enos);Pittenger, Robert (Michelle Jelnicky);Price, David;Price, David (Nora Blalock);Rouzer, David (Kyle

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: Draft 2018 list of Essential Community Providers

U.S. House and Senate Notification

Wednesday, August 31, 2016

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Draft 2018 list of Essential Community Providers

Today, the Centers for Medicare & Medicaid Services (CMS) released a draft list of Essential Community Providers (ECPs) to assist issuers with identifying providers that qualify for inclusion in an issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235 for the 2018 benefit year. Under that regulation, ECPs are defined as providers who serve predominantly low-income, medically underserved individuals. Providers included on the draft HHS ECP list for the benefit year 2018 reflect those providers who submitted an ECP petition between December 9, 2015 and July 11, 2016 and were approved by CMS for inclusion on the ECP list through the ECP petition review process.

This draft HHS list of ECPs for the benefit year 2018 is not exhaustive and does not include every provider that participates or is eligible to participate in the 340B drug program, every provider that is described under section 1927(c)(c)(1)(D)(i)(IV) of the Social Security Act, or every provider that might otherwise qualify under the regulatory standard under 45 CFR 156.235. While CMS is providing this updated draft list for the 2018 benefit year, CMS encourages providers who do not appear on the ECP list but believe they satisfy the ECP inclusion criteria, as outlined within the ECP petition, to submit an online ECP petition to CMS by no later than October 13, 2016, for inclusion on the final HHS ECP list for the benefit year 2018. The ECP petition is available at https://data.healthcare.gov/cciiio/ecp_petition.

To view the draft list of Essential Community Providers for the 2018 benefit year, visit: <https://data.healthcare.gov/view/ecf3-gujb>

If you have any questions, please contact the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 2 Jul 2013 13:38:27 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Terri Sewell (rob.nesmith@mail.house.gov);Young, M.V. (Shelby) <M.V._Young@shelby.senate.gov>;Abby.Dosoretz@mail.house.gov;Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);DeSantis, Ron (Rachel Dresen);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Grayson, Alan (Juan Lopez);Grayson, Alan (Julie Tagen);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Larry Zaragoza);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Katherine Troller);Posey, Bill;Rooney, Tom (jessica.moore@mail.house.gov);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);Wilson, Frederica (keenan.austin@mail.house.gov);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Butler, Bo (Chambliss) <Bo_Butler@chambliss.senate.gov>;Collins, Doug (Jennifer Lackey);David Scott (lauren.lattany@mail.house.gov);Doug Collins (Jason O'Rourke);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Pastor, Francie);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);Stone, Sarah (Cochran) Sarah_Stone@cochran.senate.gov;'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);Thompson, Bennie (TSMITH@mail.house.gov);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Ellmers, Renee (Josh Babb);Ellmers, Renee (Mitchell Vakerics);Hagan, Kay (mike_harney@hagan.senate.gov);Holding, George (Ryan Hart);Howard Coble (meredith.downen@mail.house.gov);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);Mark Meadows (Allison Witt) (allison.witt@mail.house.gov);'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Meadows, Mark

(Patrick Fleming);Pittenger, Robert (Michelle Jelnick);Price, David;Teitelbaum, Joshua (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Stringer, Meghan);Wade, Karen (Hagan);'Watt, Melvin';Andrae, Taylor (L. Graham);'Clyburn, James';Duncan, Jeff (Hilary Ranieri);Gowdy, Trey (Beth Webb);Gowdy, Trey (Kam Turner);Graham, Lindsey (colin_allen@lgraham.senate.gov);Joe Wilson (melissa.murphy@mail.house.gov);Mulvaney, Mick (Matt Carter);ONEill, Tara (Tara.ONEill2@mail.house.gov);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Catherine Phillips);Williams, Spencer (L. Graham);Alexander, Lamar (Alicia_Hennie@help.senate.gov);Bassett, Michael (Corker) <Michael_Bassett@corker.senate.gov>;Black, Diane (Emily Wilkinson);'Blackburn, Marsha (Cara Dalmolin)';Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Healy, Jenifer (Corker);John Duncan (patra.stephan@mail.house.gov);Lapinski, MarySumpter (HELP Committee);Phil Roe;Tatgenhorst, James (Corker) <James_Tatgenhorst@corker.senate.gov>
Cc: Lewandowski, David S. (CMS/OL);Chadwick, Alpheus K. (CMS/OL);Phillips, Josh A. (CMS/OL)
Subject: Hill Notification: Final HHS Health IT Safety Plan issued today

U.S. House and Senate Notification
Tuesday, July 2, 2013

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Subject: Final HHS Health IT Safety Plan issued today

The HHS Health IT Patient Safety Action and Surveillance Plan was issued today. The Safety Plan addresses the role of health IT in helping to eliminate medical errors, protect patients and improve the efficiency of health care.

The Safety Plan is implemented by ONC. It outlines the responsibilities to be shared across HHS and details significant participation from the private sector.

- ONC will make it easier for clinicians to report health IT-related incidents and hazards through the use of certified electronic health record technology.
- The Agency for Healthcare Research and Quality will encourage reporting to Patient Safety Organizations and will begin development of Common Formats for ambulatory care that will enhance reporting of health IT events outside the hospital.
- The Centers for Medicare & Medicaid Services (CMS) will encourage the use of the Common Formats in hospital incident reporting systems, and train surveyors to identify safe and unsafe practices associated with health IT.

- Working through a public-private process, ONC will develop priorities for improving the safety of health IT. ONC and CMS will consider adopting safety-related objectives, measures, and capabilities for certified electronic health records (EHRs) through the Medicare and Medicaid EHR Incentive Programs and ONC's standards and certification criteria.

More information, including a factsheet and the final report can be found at the following weblink: <http://www.healthit.gov/policy-researchers-implementers/health-it-and-patient-safety>.

The press release can be found here:

<http://www.hhs.gov/news/press/2013pres/07/20130702a.html>.

If you have any questions, please contact the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Dec 2015 14:33:44 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Palmer, Gary (Cari Kelly);Roby, Martha (Sophie Trainor);Sessions, Jeff (Emily_Mcbride@sessions.senate.gov);Sewell, Terri (Hillary Beard);Shelby, Richard (Dayne Cutrell);Bilirakis, Gus;Bilirakis, gus (Kristin Seum);Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Katie Wise);cesar.gonzalez@mail.house.gov;Clawson, Curt (Alyssa Wootton);Crenshaw, Ander (Catherine Skitsko);Curbelo, Carlos (Ashley Rose);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gram, Gwen (hill.thomas@mail.house.gov);Grayson, Alan (Racalto, Joe);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (Clarey Walker);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Kevin Ashley);Hastings, Alcee (Matthew Price);John Mica (Casey.Brinck@mail.house.gov);Jolly, Richard (Ian Manzano);Kobernat, Dolly (Bill Nelson);Malmgren, Corey (Bill Nelson);Mekhdjavakian, Taleen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Alyssa Wang);Nugent, Richard (Danielle Doheny);Posey, Bill (Anna Schartner);Posey, Bill (Kapavik, Christen);Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (Tim Cummings);Rubio, Marco (Eduardo Sacasa);Simon, David (Brown, Corine);Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Rachel Hall);Wasserman Schultz, Debbie (Roselyn Kumar);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Wilson, Frederica (Kyle Johnson);Allen, Rick (Hunter, Katie);Bartolomeo, Jordan (Isakson);Bishop, Sanford (jonathan.halpern@mail.house.gov);Carter, Buddy (chase.cannon@mail.house.gov);Collins, Doug (Jennifer Lackey);Collins, Doug (Katie Evans);David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov);David Scott (lauren.lattany@mail.house.gov);Eunice, John (Perdue);Graves, Tom (Bo Butler);Graves, Tom (Rebecca Anderson);Hice, Jody (Michael Calvo);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Lewis, John (Thomas Dorney);Loudermilk, Barry (Easton Randall);Perdue, David (Sarah Schatz);Price, Tom (Amanda Street);Price, Tom (Ashley Palmer);Price, Tom (DiBlasio, Carla);Scott, Austin (Beal, Mary Dee);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Barr, Andy (Francis Brooke);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);shannon.rickett@mail.house.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Whitfield, Ed (Ed Kim);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Allred, SarahLloyd (Wicker);Bennie Thompson (Cory Horton);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Nunnelee, Alan (Elliza Jones);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Anna Rush);'Thompson, Bennie';(Esther_Clark@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Alma (Margaret Franklin);Adams, Alma (Sandra Brown);Adams, Alma (Shaniqua McClendon);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Angela Boothe);Burr, Richard (Colin Rom);Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Dennis Sills);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Kristi Thompson);Holding, George (Jason Cooke);Hudson, Richard (Preston Bell);Jones, Walter (joshua.bowlen@mail.house.gov);'McHenry,

Patrick';Meadows, Mark (Zach Enos);Pittenger, Robert (Michelle Jelnicky);Price, David;Rouzer, David (Kyle Sanders);Tillis, Thom (Matt Flynn);Tillis, Thom (Ray Starling);Virginia Foxx (Stringer, Meghan);Walker, Mark (Joel Heimbach);Clyburn, James (Ashli Palmer);Duncan, Jeff (Addie Carrie);Gowdy, Trey (Nicholas Spencer);Graham, Lindsey (Jessica Phillips-Tyson);Graham, Lindsey (Nick Myers);Mulvaney, Mick (Natalee Binkholder);Prianti, Marissa (L. Graham);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Claire Brandewie);Scott, Tim (Will Holloway);Wilson, Joe (Candace Rich);Alexander, Lamar (Meeks, Brett);Black, Diane (Katie Allen);Black, Diane (Toomey, Jon);Blackburn, Marsha (Karen Summar);Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (Randy Wadkins);Cooper, Jim (Ann Waller Curtis);Corker, Bob (Hayly Humphreys);OS Vaughn, Richard;Duncan, John Jr (Lauren James);Duncan, John Jr. (Caroline DeBerry);Eblen, Alex (Corker);Fincher, Steve (Corey Schrodt);Fleischmann, Chuck (Conner Ingram);Lapinski, MarySumpter (HELP Committee);Osborn, Sarah (Corker);Phil Roe;Roe, Phil (John Martin);Tatgenhorst, James (Corker) <James_Tatgenhorst@corker.senate.gov>

Cc: Howell, Cherie A. (CMS/OL)

Subject: Hill Notification: Health Insurance Marketplace Open Enrollment Snapshot - Week 6

**U.S. House and Senate Notification
Wednesday, December 16, 2015**

To: Congressional Health Staff

**From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: Health Insurance Marketplace Open Enrollment Snapshot - Week 6

More than 1.3 million consumers signed-up for health coverage through the HealthCare.gov platform between December 6 and December 12, the last full week before the deadline for January 1 coverage, bringing the total number of plan selections made since Open Enrollment began on November 1 to 4.17 million consumers. Approximately 500,000 were new consumers, for a cumulative total of about 1.5 million new consumers since the beginning of Open Enrollment.

Because of the unprecedented demand and volume of consumers contacting our call center or visiting HealthCare.gov, CMS extended the deadline to sign-up for January 1 coverage until 11:59pm PST December 17. Hundreds of thousands have already selected plans on December 14 and 15 and approximately 1 million consumers have left their contact information to hold their place in line.

Similar to last year, each week, the Centers for Medicare and Medicaid Services (CMS) will release weekly Open 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 weekly plan selections, call center activity and visits to HealthCare.gov or CuidadoDeSalud.gov. The final number of plan selections associated with enrollment activity to date could fluctuate as plan changes or

cancellations occur, such as in response to life changes like starting a new job or getting married. In addition, the weekly snapshot only looks at new plan selections, active plan renewals and, starting at the end of December, auto-renewals and does not include the number of consumers who paid their premiums to effectuate their enrollment.

HHS will produce more detailed reports that look at plan selections across the Federally-facilitated Marketplace and State-based Marketplaces later in the Open Enrollment period.

Federal Marketplace Snapshot

Federal Marketplace Snapshot	Week 6 Dec 6 – Dec 12	Cumulative Nov 1 – Dec 12
Plan Selections (net)	1,326,946	4,171,714
<i>New Consumers</i>	38 percent	36 percent
<i>Consumers Renewing Coverage</i>	62 percent	64 percent
Applications Submitted (Number of Consumers)	1,604,633	6,147,257
Call Center Volume	1,511,082	5,383,321
Average Call Center Wait Time	22 minutes 44 seconds	9 minutes 55 seconds
Calls with Spanish Speaking Representative	89,262	338,906
Average Wait for Spanish Speaking Rep	19 seconds	14 seconds
HealthCare.gov Users	3,601,900	13,512,506
CuidadoDeSalud.gov Users	208,935	480,269
Window Shopping HealthCare.gov Users	1,357,120	4,718,633
Window Shopping CuidadoDeSalud.gov Users	21,249	80,195

HealthCare.gov State-by-State Snapshot

Consumers across the country continued to explore their health insurance options by reaching out to a call center representative at 1-800-318-2596, attending enrollment events in their local communities, or visiting HealthCare.gov or CuidadoDeSalud.gov. Individual plan selections for the states using the HealthCare.gov platform include:

Week 6	Cumulative Nov 1 – Dec 12
Alabama	88,108
Alaska	9,344
Arizona	94,928
Arkansas	26,608
Delaware	11,139

Florida	834,938
Georgia	229,552
Hawaii	8,060
Illinois	154,947
Indiana	73,943
Iowa	24,442
Kansas	50,000
Louisiana	88,175
Maine	37,210
Michigan	138,765
Mississippi	33,773
Missouri	129,536
Montana	25,103
Nebraska	43,944
Nevada	43,876
New Hampshire	21,277
New Jersey	121,592
New Mexico	22,440
North Carolina	280,080
North Dakota	9,344
Ohio	97,786
Oklahoma	58,621
Oregon	74,523
Pennsylvania	212,605
South Carolina	112,745
South Dakota	13,905
Tennessee	125,777
Texas	474,616
Utah	80,887
Virginia	178,465
West Virginia	15,615
Wisconsin	112,457
Wyoming	12,588

The snapshot report can be found here:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-16.html>

If you have any questions, please contact the CMS Office of Legislation. Thank you.

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Sent: 22 Dec 2015 14:33:12 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Palmer, Gary (Cari Kelly);Roby, Martha (Sophie Trainor);Sessions, Jeff (Emily_Mcbride@sessions.senate.gov);Sewell, Terri (Hillary Beard);Shelby, Richard (Dayne Cutrell);Bilirakis, Gus;Bilirakis, gus (Kristin Seum);Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Edward Kim);cesar.gonzalez@mail.house.gov;Clawson, Curt (Alyssa Wootton);Crenshaw, Ander (Catherine Skitsko);Curbelo, Carlos (Ashley Rose);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gram, Gwen (hill.thomas@mail.house.gov);Grayson, Alan (Racalto, Joe);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (Clarey Walker);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Kevin Ashley);Hastings, Alcee (Matthew Price);John Mica (Casey.Brinck@mail.house.gov);Jolly, Richard (Ian Manzano);Kobernat, Dolly (Bill Nelson);Malmgren, Corey (Bill Nelson);Mekhdjavakian, Taleen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Alyssa Wang);Nugent, Richard (Danielle Doheny);Posey, Bill (Anna Schartner);Posey, Bill (Kapavik, Christen);Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (Tim Cummings);Rubio, Marco (Eduardo Sacasa);Simon, David (Brown, Corine);Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Rachel Hall);Wasserman Schultz, Debbie (Roselyn Kumar);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Wilson, Frederica (Kyle Johnson);Allen, Rick (Hunter, Katie);Bartolomeo, Jordan (Isakson);Bishop, Sanford (jonathan.halpern@mail.house.gov);Carter, Buddy (chase.cannon@mail.house.gov);Collins, Doug (Jennifer Lackey);Collins, Doug (Katie Evans);David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov);David Scott (lauren.lattany@mail.house.gov);Eunice, John (Perdue);Graves, Tom (Bo Butler);Graves, Tom (Rebecca Anderson);Hice, Jody (Michael Calvo);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Lewis, John (Thomas Dorney);Loudermilk, Barry (Easton Randall);Perdue, David (Sarah Schatz);Price, Tom (Amanda Street);Price, Tom (Ashley Palmer);Price, Tom (DiBlasio, Carla);Scott, Austin (Beal, Mary Dee);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Barr, Andy (Francis Brooke);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);shannon.rickett@mail.house.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Allred, SarahLloyd (Wicker);Bennie Thompson (Cory Horton);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Nunnelee, Alan (Elliza Jones);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Anna Rush);'Thompson, Bennie';(Esther_Clark@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Alma (Margaret Franklin);Adams, Alma (Sandra Brown);Adams, Alma (Shaniqua McClendon);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Angela Boothe);Burr, Richard (Colin Rom);Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Dennis Sills);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Kristi Thompson);Holding, George (Jason Cooke);Hudson, Richard (Preston Bell);Jones, Walter (joshua.bowlen@mail.house.gov);'McHenry, Patrick';Meadows, Mark (Zach Enos);Pittenger, Robert

(Michelle Jelnicky);Price, David;Price, David (Nora Blalock);Rouzer, David (Kyle Sanders);Tillis, Thom (Matt Flynn);Tillis, Thom (Ray Starling);Virginia Foxx (Stringer, Meghan);Walker, Mark (Joel Heimbach);Clyburn, James (Ashli Palmer);Duncan, Jeff (Addie Carrie);Gowdy, Trey (Nicholas Spencer);Graham, Lindsey (Jessica Phillips-Tyson);Graham, Lindsey (Nick Myers);Mulvaney, Mick (Natalee Binkholder);Prianti, Marissa (L. Graham);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Claire Brandewie);Scott, Tim (Will Holloway);Wilson, Joe (Candace Rich);Alexander, Lamar (Meeks, Brett);Black, Diane (Katie Allen);Black, Diane (Toomey, Jon);Blackburn, Marsha (Karen Summar);Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (Randy Wadkins);Cooper, Jim (Ann Waller Curtis);Corker, Bob (Hayly Humphreys);OS Vaughn, Richard;Duncan, John Jr (Lauren James);Duncan, John Jr. (Caroline DeBerry);Eblen, Alex (Corker);Fincher, Steve (Corey Schrodtt);Fleischmann, Chuck (Conner Ingram);Lapinski, MarySumpter (HELP Committee);Osborn, Sarah (Corker);Phil Roe;Roe, Phil (John Martin);Tatgenhorst, James (Corker)
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Cc: Saklas, Ariadne (CMS/OL);Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: Health Insurance Marketplace Open Enrollment Snapshot - Week 7

U.S. House and Senate Notification
Tuesday, December 22, 2015

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Health Insurance Marketplace Open Enrollment Snapshot - Week 7

Since Open Enrollment began on November 1, more than 8.2 million consumers signed up for health coverage through the HealthCare.gov platform or had their coverage automatically renewed – with millions more selecting plans through State-based Marketplaces. Last year at this time, about 6.4 million had signed up for coverage or been automatically renewed by December 19, 2014. Since November 1, about 2.4 million new consumers signed up for Marketplace coverage, over one-third higher than the number of new consumers that signed up by the deadline for January 1 coverage last year. Between December 13 and December 19, more than 4 million people selected plans or had their coverage automatically renewed. High consumer demand as we neared the enrollment deadline for January 1 coverage, as well as the automatic renewal process, contributed to this overall total.

This snapshot, for the first time, reflects the vast majority of consumers who were automatically re-enrolled into 2016 coverage. The re-enrollment process has not yet been completed so as it continues, upcoming snapshots will include additional consumers who were automatically re-enrolled after December 19.

Similar to last year, each week, the Centers for Medicare and Medicaid Services (CMS) will continue to release weekly Open 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 weekly plan selections, call center activity and visits to HealthCare.gov or CuidadoDeSalud.gov. The final number of plan selections associated with enrollment activity to date could fluctuate as plan changes or cancellations occur, such as in response to life changes like starting a new job or getting married. In addition, the weekly snapshot only looks at new plan selections, active plan renewals and auto-renewals and does not include the number of consumers who paid their premiums to effectuate their enrollment.

HHS will produce more detailed reports that look at plan selections across the Federally-facilitated Marketplace and State-based Marketplaces later in the Open Enrollment period.

Federal Marketplace Snapshot

Federal Marketplace Snapshot	Week 7 Dec 13 – Dec 19	Cumulative Nov 1 – Dec 19
Plan Selections (net)	4,078,562	8,250,276
<i>New Consumers</i>	22 percent	29 percent
<i>Consumers Renewing Coverage</i>	78 percent	71 percent
Applications Submitted (Number of Consumers)	*	*
Call Center Volume	3,015,283	8,398,604
Average Call Center Wait Time	31 minutes 17 seconds	14 minutes 01 seconds
Calls with Spanish Speaking Representative	140,887	479,793
Average Wait for Spanish Speaking Rep	59 seconds	24 seconds
HealthCare.gov Users	5,720,153	17,864,639
CuidadoDeSalud.gov Users	329,990	747,206
Window Shopping HealthCare.gov Users	2,351,732	6,572,823
Window Shopping CuidadoDeSalud.gov Users	55,201	129,384

**Validated data on applications submitted was not available at the time of publication.*

HealthCare.gov State-by-State Snapshot

Consumers across the country continued to explore their health insurance options by reaching out to a call center representative at 1-800-318-2596, attending enrollment events in their local communities, or visiting HealthCare.gov or CuidadoDeSalud.gov. Individual plan selections for the states using the HealthCare.gov platform include:

Week 7	Cumulative Nov 1 – Dec 19
Alabama	169,596
Alaska	20,573

Arizona	155,050
Arkansas	62,679
Delaware	25,241
Florida	1,507,707
Georgia	498,901
Hawaii	10,856
Illinois	340,479
Indiana	177,821
Iowa	48,514
Kansas	84,631
Louisiana	179,014
Maine	76,663
Michigan	311,100
Mississippi	90,358
Missouri	253,099
Montana	54,517
Nebraska	77,996
Nevada	72,627
New Hampshire	49,918
New Jersey	247,739
New Mexico	44,477
North Carolina	544,950
North Dakota	19,183
Ohio	218,047
Oklahoma	124,135
Oregon	128,667
Pennsylvania	394,302
South Carolina	189,552
South Dakota	22,354
Tennessee	227,102
Texas	1,040,246
Utah	143,391
Virginia	375,891
West Virginia	33,407
Wisconsin	209,345
Wyoming	20,148

The snapshot report can be found here:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-22.html>

If you have any questions, please contact the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 22 Dec 2015 14:42:01 -0500
To: Howell, Cherie A. (CMS/OL);Rep. Young;Sen. Murkowski;Sen. Sullivan;Sen. Sullivan;Rep. Womack;Rep. Crawford;Rep. Crawford;Rep. Hill;Rep. Westerman;Sen. Boozman;Sen. Cotton (Brian_colas@cotton.senate.gov);Rep. Labrador (Aaron.calkins@mail.house.gov);Rep. Simpson;Sen. Crapo;Sen. Risch (Rachel_burkett@risch.senate.gov);Rep. Abraham;Rep. Boustany;Rep. Boustany;Rep. Fleming;Rep. Garret Graves;Rep. Graves;Rep. Richmond;Rep. Scalise;Sen. Cassidy;Sen. Vitter;Rep. Lujan;Rep. Lujan;Rep. Lujan;Rep. Lujan (Jeffery.bustamante@mail.house.gov);Rep. Lujan Grisham;Rep. Lujan Grisham;Rep. Pearce;Rep. Pearce (Patrick.cuff@mail.house.gov);Sen. Heinrich;Sen. Udall;Rep. Bridenstine (mark.piland@mail.house.gov);Rep. Cole;Rep. Lucas;Rep. Mullin (Adam.Buckalew@mail.house.gov);Rep. Russell;Sen. Inhofe;Sen. Lankford (Katherine_Mayne@lankford.senate.gov);Rep. Blumenauer;Rep. Bonamici;Rep. Bonamici;Rep. Defazio;Rep. DeFazio (kris.pratt@mail.house.gov);Rep. Schrader;Rep. Walden;Rep. Blumenauer;Sen. Merkley (Susan_Lexer@merkle.senate.gov);Sen. Wyden;Rep. O'Rourke;Rep. AL Green;Rep. Babin;Rep. Babin;Rep. Barton;Rep. Brady;Rep. Brady;Rep. Burgess;Rep. Castro;Rep. Conaway;Rep. Cuellar (Ryan.Ehly@mail.house.gov);Rep. Culberson;Rep. Culberson;Rep. Doggett;Rep. Doggett;Rep. Eddie Bernice Johnson;Rep. Farenthold;Rep. Flores;Rep. Gene Green;Rep. Gohmert;Rep. Granger;Rep. Hensarling;Rep. Hinojosa;Rep. Hurd;Rep. Jackson Lee;Rep. Marchant;Rep. McCaul;Rep. Neugebauer;Rep. Olson;Rep. Orourke;Rep. Poe;Rep. Ratcliffe;Rep. Sam Johnson;Rep. Sessions (elle.ross@mail.house.gov);Rep. Smith;Rep. Smith;Rep. Thornberry;Rep. Veasey (kenny.palmer@mail.house.gov);Rep. Vela (jasey.cardenas@mail.house.gov);Rep. Weber;Rep. Williams;Sen. Cornyn;Sen. Cornyn;Sen. Cruz;Rep. Adam Smith;Rep. DelBene;Rep. Heck;Rep. Heck;Rep. Heck;Rep. Heck;Rep. Herrera;Rep. Kilmer;Rep. Larsen (matt.renninger@mail.house.gov);Rep. McDermott;Rep. McMorris Rodgers;Rep. Newhouse;Rep. Reichert;Sen. Cantwell;Sen. Cantwell;Sen. Murray (madeleine_pannell@help.senate.gov)
Cc: Saklas, Ariadne (CMS/OL);Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Health Insurance Marketplace Open Enrollment Snapshot - Week 7

U.S. House and Senate Notification
Tuesday, December 22, 2015

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Health Insurance Marketplace Open Enrollment Snapshot - Week 7

Since Open Enrollment began on November 1, more than 8.2 million consumers signed up for health coverage through the HealthCare.gov platform or had their coverage automatically renewed – with millions more selecting plans through State-based Marketplaces. Last year at this time, about 6.4 million had signed up for coverage or been automatically renewed by December 19, 2014. Since November 1, about 2.4 million new consumers signed up for Marketplace coverage, over one-third higher than the number of new consumers that signed up by the deadline for January 1 coverage last year. Between December 13 and December 19, more than 4

million people selected plans or had their coverage automatically renewed. High consumer demand as we neared the enrollment deadline for January 1 coverage, as well as the automatic renewal process, contributed to this overall total.

This snapshot, for the first time, reflects the vast majority of consumers who were automatically re-enrolled into 2016 coverage. The re-enrollment process has not yet been completed so as it continues, upcoming snapshots will include additional consumers who were automatically re-enrolled after December 19.

Similar to last year, each week, the Centers for Medicare and Medicaid Services (CMS) will continue to release weekly Open 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 weekly plan selections, call center activity and visits to HealthCare.gov or CuidadoDeSalud.gov. The final number of plan selections associated with enrollment activity to date could fluctuate as plan changes or cancellations occur, such as in response to life changes like starting a new job or getting married. In addition, the weekly snapshot only looks at new plan selections, active plan renewals and auto-renewals and does not include the number of consumers who paid their premiums to effectuate their enrollment.

HHS will produce more detailed reports that look at plan selections across the Federally-facilitated Marketplace and State-based Marketplaces later in the Open Enrollment period.

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Illinois	340,479
Indiana	177,821
Iowa	48,514
Kansas	84,631
Louisiana	179,014
Maine	76,663
Michigan	311,100
Mississippi	90,358
Missouri	253,099
Montana	54,517
Nebraska	77,996
Nevada	72,627
New Hampshire	49,918
New Jersey	247,739
New Mexico	44,477
North Carolina	544,950
North Dakota	19,183
Ohio	218,047
Oklahoma	124,135
Oregon	128,667
Pennsylvania	394,302

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Wyoming	20,148

The snapshot report can be found here:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-22.html>

If you have any questions, please contact the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 18 Oct 2011 16:50:20 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James)';Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Helpful Beneficiary Resources for the Medicare Open Enrollment
Attachments: HHS Press Release open enrollment 10-12-11.pdf, Inventory_of_Open_Enrollment_Materials_9_30_11.pdf

U.S. House and Senate Notification
Tuesday, October 18, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Helpful Beneficiary Resources for the Medicare Open Enrollment: October 15 - December 7

The Medicare Advantage and Part D Open Enrollment Period kicked off on Saturday October 15th. This Hill Notification includes some helpful resources that are available for making 2012 plan decisions. In addition to the 2012 Medicare & You Handbook, CMS is providing you with electronic versions of the Open Enrollment Press Release and the Inventory of Open Enrollment Materials for your convenience (see attached).

Besides the Medicare & You Handbook already received by beneficiaries in the mail, there are a number of useful electronic resources and tools available on the web. People with Medicare, their families, and other trusted representatives can review and compare current plan coverage with new plan offerings by using the following resources:

- www.medicare.gov/find-a-plan, for personalized comparison of costs and coverage of the plans available in their area. The popular Medicare Plan Finder tool has been enhanced for an efficient review of plan choices. Spanish Open Enrollment information is available.
- 1-800-MEDICARE (1-800-633-4227) for around-the-clock assistance to find out more about coverage options. TTY users should call 1-877-486-2048. Multilingual counseling is available.
- The 2012 Medicare & You handbook is online at: <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>
- The Medicare & You 2012 handbook in Spanish is online at: <http://www.medicare.gov/Publications/Pubs/pdf/10050-S.pdf>
- The local State Health Insurance Assistance Program (SHIP) at: <https://shiptalk.org/public/home.aspx?ReturnUrl=%2f>. Local SHIP contact information can also be found at: <http://www.medicare.gov/contacts/organization-search-criteria.aspx>; on the back of the 2011 Medicare & You handbook; or by calling 1-800-MEDICARE.

Other helpful information can be found here:

- 2012 MA and Drug Plan State Fact Sheets – <http://www.cms.gov/center/openenrollment.asp>
- CMS Administrator, Don Berwick blog post on Open Enrollment – <http://blog.medicare.gov/2011/10/03/medicare-open-enrollment-medicare-is-stronger-than-ever/>
- CMS Deputy Administrator, Jon Blum blog post on Comparing MA plans – <http://blog.medicare.gov/2011/10/17/medicare-open-enrollment-things-to-think-about-when-comparing-plans/>

People with Medicare who have limited incomes and resources who may qualify for Extra Help paying for their prescription drug costs (i.e.: the low income subsidy) can apply online at: www.socialsecurity.gov/prescriptionhelp or call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778).

During this Open Enrollment Period, CMS reminds people with Medicare to never give their personal information to anyone arriving at their home uninvited or making unsolicited phone calls selling Medicare-related products or services. Beneficiaries who believe they are a victim of fraud or identity theft should contact 1-800-MEDICARE. More information is available at www.stopmedicarefraud.gov

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220. Thank you.



FOR IMMEDIATE RELEASE

Wednesday, October 12, 2011

Contact: HHS Press Office

(202) 690-6343

Medicare Open Enrollment begins Saturday -- seniors have more benefits, better choices, lower costs

Affordable Care Act gives seniors with Medicare cheaper prescription drugs, free preventive services, and lower costs

With more benefits, better choices and lower costs, the Centers for Medicare & Medicaid Services (CMS) is encouraging people with Medicare and their families to begin reviewing drug and health plan coverage options for 2012. The Medicare Open Enrollment Period -- which begins earlier this year on Saturday, October 15 – has been expanded to last seven weeks and will end on December 7. This will give seniors and people with disabilities more time to compare and find the best plan that meets their unique needs. Across the country, HHS officials will hold 150 events in the days leading up to Medicare’s Open Enrollment Period to inform and educate people with Medicare.

“Thanks to the Affordable Care Act, people with Medicare can get certain preventive services for free and can get more affordable prescription drugs,” said HHS Secretary Kathleen Sebelius. “Open enrollment is seniors’ chance to review their Medicare choices and pick the plan that works for them, or keep the plan they have today.”

Beginning today, people with Medicare can begin reviewing the 2012 quality ratings for Medicare Advantage health plans (Part C) and prescription drug plans (Part D) for the upcoming year.

This year CMS is highlighting plans that have achieved an overall quality rating of 5 stars with a high performer or “gold star” icon so people with Medicare can easily find high quality plans. People with Medicare can switch to an available 5-star plan at any time during the year.

Using Medicare’s Plan Finder – available at www.medicare.gov/find-a-plan – people will see the enhanced star ratings for 2012. In addition to the enhanced star ratings for 2012 and new “gold star” icon, Plan Finder users will see an icon showing which plans received a low overall quality rating for the past three years.

“Over the past year, we have worked to improve health coverage choices for people with Medicare, and make it easier for people to find a plan that is both a good value and meets their health care needs,” said CMS Administrator Donald M. Berwick, M.D. “Due to these efforts, people with Medicare have good, meaningful choices for their 2012 plan options.”

In 2012, thanks to the Affordable Care Act, additional benefits to people with Medicare include lower prescription drug costs through a 50 percent discount on covered brand name drugs in the coverage gap (also referred to as the “donut hole”), wellness checkups, and access to certain preventive care with no copayments – a benefit that all Medicare Advantage plans will offer starting in 2012.

Resources for Medicare Beneficiaries

People with Medicare, their families and other trusted representatives can review and compare current plan coverage with new plan offerings, using many proven resources, including:

- Visiting www.medicare.gov, where they can get a personalized comparison of costs and coverage of the plans available in their area. The popular Medicare Plan Finder tool has been enhanced for an efficient review of plan choices. Spanish Open Enrollment information is available.
- Calling 1-800-MEDICARE (1-800-633-4227) for around-the-clock assistance to find out more about coverage options. TTY users should call 1-877-486-2048. Multilingual counseling is available.
- Reviewing the 2012 *Medicare & You* handbook. It is also accessible online at: <http://www.medicare.gov/publications/pubs/pdf/10050.pdf> -- and it has been mailed to the homes of people with Medicare.
- Getting one-on-one counseling assistance from the local State Health Insurance Assistance Program (SHIP). Local SHIP contact information can be found:
 - At <http://www.medicare.gov/contacts/organization-search-criteria.aspx> or
 - On the back of the 2011 *Medicare & You* handbook or;
 - By calling Medicare (contact information above).
 - Through a listing of national stand-alone prescription drug plans and State specific fact sheets can be found at: <http://www.cms.hhs.gov/center/openenrollment.asp>

People with Medicare who have limited incomes and resources may qualify for Extra Help paying for their prescription drug costs. There is no cost to apply for Extra Help, also called the low-income subsidy. Medicare beneficiaries, family members, trusted counselors or caregivers can apply online at www.socialsecurity.gov/prescriptionhelp or call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) to find out more.

Protecting Against Fraud and Identity Theft

During this Open Enrollment Period, Medicare recommends that people treat their Medicare number as they do their social security number and credit card information. People with Medicare should never give their personal information to anyone arriving at their home uninvited or making unsolicited phone calls selling Medicare-related products or services. Beneficiaries who believe they are a victim of fraud or identity theft should contact Medicare (contact information above). More information is available at www.stopmedicarefraud.gov

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Note: All HHS press releases, fact sheets and other press materials are available at <http://www.hhs.gov/news>.

Open Enrollment 2011

Inventory of Materials

These materials are recommended for Open Enrollment. To order beneficiary materials, visit the [CMS Product Ordering Web site \(http://productordering.cms.hhs.gov\)](http://productordering.cms.hhs.gov). First-time users should select “create an account” to get started. Once you create an account, you will get an e-mail within 3 business days approving your request to log on and order.

Materials – For People with Medicare

Title	Publication Number and Links to Other Languages	Description	Print Availability
<i>Medicare & You Handbook</i>	10050 (Also available in Spanish .)	A comprehensive resource about Medicare benefits.	Mailed to people with Medicare. Coming soon to warehouse.
<i>Have you done Your Yearly Medicare Plan Review?</i>	11220 (Also available in Spanish – current version being translated.) Currently being translated into Korean, Vietnamese, Chinese, Russian, & Tagalog.	A 5-page fact sheet that provides information to help people with Medicare review their health and prescription drug coverage in the fall.	Coming soon!
<i>Things to Think about When You Compare Medicare Drug Coverage</i>	11163 (Also available in Spanish .)	A 6-page tip sheet that explains things to consider when comparing Medicare drug plans.	Available in print in English and Spanish.
<i>Understanding Medicare Enrollment Periods</i>	11219 (Also available in Spanish – current version being translated.)	A 12-page tip sheet to help you learn more about enrollment in the different parts of Medicare, including who can sign up, when you can sign up, and how the timing can affect your costs.	Coming soon!
<i>A Quick Look at Medicare</i>	11514 (Also available in Spanish .) Available in Korean , Vietnamese , and Chinese . Currently being translated in Russian & Tagalog.	This 4-page brochure provides basic information about how Medicare works.	Available now
<i>Open Enrollment Sticker</i>	11574	Sticker highlighting new open enrollment dates.	Shipped to ROs, AOAs & SHIPs.
<i>Open Enrollment Poster</i>	11573	Poster highlighting the new open enrollment dates.	Shipped to ROs, AOAs & SHIPs.
<i>Open Enrollment Reminder Postcard - in development</i>	11585	A reminder to sign up during the new open enrollment timeframe.	Postcard to be mailed in November to every Medicare beneficiary household

<i>MyMedicare.gov/Blue Button conference card – in development</i>	11424 (Also available in Spanish.) English currently being revised.	A 2-sided conference card advertising MyMedicare.gov and the “Blue Button.”	New version coming soon!
<i>Open Enrollment Conference Card</i>	11572	Conference card highlighting the new open enrollment dates.	Out of Stock – more coming soon!
<i>Staying Healthy</i>	<u>11100</u> (Also available in <u>Spanish</u> .) Currently being translated into Tagalog, Chinese, Russian, Vietnamese, & Korean.	A 4-page product that gives an overview of Medicare’s covered preventive services.	Available now in English and Spanish.
<i>Are you up-to-date on your Preventive Services?</i>	<u>11420</u> (Also available in <u>Spanish</u> .)	A 2-page easy-to-use checklist of Medicare-covered preventive services.	Available now in English and Spanish.
<i>Questions to Ask about Medicare Preventive Services</i>	<u>11542</u> (Also available in <u>Spanish</u> .)	A trifold brochure that includes a list of questions to ask your doctor about Medicare's preventive services.	Available now in Spanish. English on back order.
<i>Your Guide to Medicare’s Preventive Services</i>	<u>10110</u> (Also available in <u>Spanish</u> .)	A 28-page booklet that gives an overview of Medicare's covered preventive services.	Out of stock – more copies coming soon!
<i>Bridging the Coverage Gap in 2011</i>	<u>11213</u> (Also available in <u>Spanish</u> .)	A 2-page fact sheet that provides information and resources to people with Medicare prescription drug coverage during the coverage gap.	Available now in English and Spanish.
<i>Closing the Coverage Gap – More Prescription Drugs Are Becoming Affordable</i>	<u>11493</u> (Also available in <u>Spanish</u> .)	This 8-page fact sheet explains the discount on brand-name drugs and coverage for generic drugs during the coverage gap and how these benefits will increase over time until the coverage gap is closed by 2020.	Available now in English and Spanish.
<i>Welcome to Medicare Preventive Visit</i>	<u>11532</u> (Also available in <u>Spanish</u> .) Available in <u>Chinese</u> , <u>Korean</u> , <u>Vietnamese</u> . To be translated in Russian & Tagalog.	A 2-page fact sheet of questions and answers about the Welcome to Medicare Preventive Visit.	Available now in English, Spanish, Chinese, Korean and Vietnamese.
<i>6 Things You Should Know</i>	<u>11533</u> (Also available in <u>Spanish</u> .) Available in <u>Chinese</u> , <u>Korean</u> , and <u>Vietnamese</u> .	A 2-page fact sheet about the 6 things you should know about the Welcome to Medicare Preventive Visit.	Available now in English, Spanish, Chinese, Korean and Vietnamese.

Updated 9.30.11

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 11 Jul 2011 11:42:07 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan

(patra.stephan@mail.house.gov);Lamar Alexander (marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS, States Move to Establish Affordable Insurance Exchanges

U.S. House and Senate Notification

Monday, July 11, 2011

To: Congressional Health Staff

From: Amy Hall

Director, Office of Legislation

Centers for Medicare & Medicaid Services

Re: HHS, States Move to Establish Affordable Insurance Exchanges

Today, the U.S. Department of Health and Human Services (HHS) proposed a framework to assist States in building Affordable Insurance Exchanges, state-based competitive marketplaces where individuals and small businesses will be able to purchase affordable private health insurance and have the same insurance choices as Members of Congress. Starting in 2014, Exchanges will make it easy for individuals and small businesses to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP), and enroll in a health plan that meets their needs.

Today's announcement is designed to help support and guide States in their efforts to implement Exchanges. HHS proposed new rules offering States guidance and options on how to structure their Exchanges in two key areas:

- Setting standards for establishing Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange, and certifying health plans for participation in the Exchange, and;
- Ensuring premium stability for plans and enrollees in the Exchange, especially in the early years as new people come in to Exchanges to shop for health insurance

The proposed rules set minimum standards for Exchanges, give states the flexibility they need to design Exchanges that best fit their unique insurance markets, and are consistent with steps States have already taken to move forward with Exchanges. States may decide whether their Exchanges should be local, regional, or operated by a non-profit organization, how to select plans to participate, and whether to partner with HHS to split up the work.

Forty-nine states, the District of Columbia and four territories accepted grants to help plan and operate Exchanges. In addition, over half of all States are taking additional action beyond receiving a planning grant such as passing legislation or taking Administrative action to begin building exchanges. States will continue to implement exchanges on different schedules through 2014.

HHS is accepting public comment on the proposed rules over the next 75 days to learn from states, consumers, and other stakeholders how the rules can be improved and HHS will modify these proposals based on feedback from the American people. To facilitate that public comment process, HHS will convene a series of regional listening sessions and meetings.

To reduce duplication of effort and the administrative burden on the States, HHS also announced that the Federal government will partner with states to make Exchange development and operations more efficient. States can choose to develop an Exchange in partnership with the Federal government or develop these systems themselves. This provides states more flexibility to focus their resources on designing the right Exchanges for their local insurance markets.

The proposed regulations can be found here:

[http://www.ofr.gov/\(X\(1\)S\(nkajqyro13oelz2ffeeho3z\)\)/OFRUpload/OFRData/2011-17610_PI.pdf](http://www.ofr.gov/(X(1)S(nkajqyro13oelz2ffeeho3z))/OFRUpload/OFRData/2011-17610_PI.pdf) and here: [http://www.ofr.gov/\(X\(1\)S\(nkajqyro13oelz2ffeeho3z\)\)/OFRUpload/OFRData/2011-17609_PI.pdf](http://www.ofr.gov/(X(1)S(nkajqyro13oelz2ffeeho3z))/OFRUpload/OFRData/2011-17609_PI.pdf)

For more information on Exchanges, including fact sheets, visit <http://www.healthcare.gov/exchanges>

If you have any questions, please contact the CMS office of Legislation AT 202-690-8220. Thank you.

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Nov 2012 11:25:18 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Hunt, Lauren (CMS/CQISO);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Terri Sewell (rob.nesmith@mail.house.gov);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;Ileana Ros-Lehtinen (golan.rodgers@mail.house.gov);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Sandy Adams (Coleman Garrison);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (keenan.austin@mail.house.gov);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Pastor, Francie);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn)';'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam)';'Price, Tom';'Price, Tom (Emily Henehan)';'Price, Tom (Natalie.Burkhalter@mail.house.gov)';Scott, Austin (Jessica Robertson)';'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (Williams, Bethany)';'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);Katelyn Conner; 'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Edward (jeff.mortier@mail.house.gov);Adam Buckalew;Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);Stone, Sarah (Cochran) Sarah_Stone@cochran.senate.gov;'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Lee Lilley);Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Howard Coble (meredith.downen@mail.house.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Teitelbaum, Joshua (Hagan);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Wade, Karen (Hagan)';'Watt, Melvin';Andreae, Taylor (L. Graham);Aramanda, Alec (DeMint)';Clyburn, James';Gowdy, Trey (Beth Webb);Gowdy, Trey (Kam Turner);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Williams, Spencer (L. Graham);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim

(elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander (marysumpter_lapinski@alexander.senate.gov);Lamar Alexander (TN) (brandon_ball@alexander.senate.gov);Phil Roe
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: HHS Announces Medicare Premium, Deductibles, and Coinsurance Amounts for 2013

**U.S. House and Senate Notification
Friday, November 16, 2012**

To: Congressional Health Staff

**From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: HHS Announces Medicare Premium, Deductibles, and Coinsurance Amounts for 2013

The U.S. Department of Health and Human Services (HHS) today announced the Medicare Part A and Part B premiums, deductibles and coinsurance amounts for 2013.

The Medicare Part B standard premium in 2013 will be \$104.90, a slight increase over last year's premium of \$99.90, and the Part B deductible will be \$147. Medicare Part B covers physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

HHS also announced a decrease in Medicare Part A monthly premiums as well as modest increases in the Part A deductible. Monthly premiums for Medicare Part A, which pays for inpatient hospitals, skilled nursing facilities, and some home health care, are paid by about 1 percent of beneficiaries who do not automatically qualify for Medicare.

- Medicare Part A monthly premiums will be \$441 for 2013, a decrease of \$10 from 2012.
- The Part A deductible paid by beneficiaries when admitted as a hospital inpatient will be \$1,184 in 2013, an increase of \$28 from last year's deductible of \$1,156.

The Federal Register posting can be found at: www.ofr.gov/inspection.aspx

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 18 Oct 2011 12:38:58 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Announces Regulatory Reductions to Save Health Care System Nearly \$1.1 billion

Attachments: Hospital CoP release Oct 18 2011.pdf, Oct 18 2011_CoP Reg Reform ASC Fact Sheet_FINAL to post.pdf

U.S. House and Senate Notification

Tuesday, October 18, 2011

To: Congressional Health Staff

From: Amy Hall

Director, Office of Legislation

Centers for Medicare & Medicaid Services

Re: HHS Announces Regulatory Reductions to Save Health Care System Nearly \$1.1 billion

New proposed rules released today by the Centers for Medicare & Medicaid Services would reduce unnecessary, obsolete, or burdensome regulations and save hospitals and healthcare providers nearly \$1.1 billion each year and over \$5 billion over 5 years. The new proposals regarding the rules for hospitals that treat Medicare and Medicaid patients were developed in response to President Obama's call on all Federal agencies to eliminate burdensome and unnecessary regulations.

CMS proposed two sets of regulatory reforms today, and finalized a third. All are designed to improve transparency and help providers operate more efficiently by reducing their regulatory burden. One set proposes to update the rules for hospitals that treat Medicare and Medicaid patients -- the Medicare Conditions of Participation. As an example, the proposed reforms would consolidate patient care plans and eliminate outdated requirements for hospital management. This could save hospitals over \$900 million per year and perhaps grow to much more over time as hospitals increasingly use this new flexibility.

The second set of reforms address regulatory requirements for providers other than hospitals and could save up to \$200 million in the first year. The rule would identify and begin to eliminate duplicative, overlapping, outdated, and conflicting regulatory requirements for healthcare providers and suppliers such as end-stage renal disease facilities and durable medical equipment suppliers. Examples of these reforms include updating obsolete e-prescribing technical requirements to meet current standards and eliminating other out-of-date and overly prescriptive requirements for healthcare providers.

CMS is also finalizing a third rule that reduces regulatory burden for ambulatory surgical centers (ASCs), which is expected to save ASCs \$50 million per year. This rule makes common-sense changes to the requirements ASCs must follow in order to meet Medicare and Medicaid health and safety standards.

To view the proposed and final rules, please visit: www.ofr.gov/inspection.aspx.

Both proposals invite the public, including doctors, hospitals, patient advocates, and other stakeholders, to comment. To submit a comment, visit www.regulations.gov, enter the ID number CMS-9070-P or CMS-3244-P, and click on “Submit a Comment.”

For additional information on the Department of Health and Human Services overall Plan for Retrospective Review of Existing Rules, visit http://www.hhs.gov/open/execorders/13563/hhs_final_retrospective_review_plan_8-19-11_4.pdf.

Please find attached a press release and fact sheet regarding this announcement. If you have any questions, please contact the CMS Office of Legislation. Thank you.



FOR IMMEDIATE RELEASE

Tuesday, October 18, 2011

Contact: HHS Press Office
(202) 690-6343

Obama Administration's regulatory reductions to save health care system nearly \$1.1 billion
Scaling back outdated rules is part of Administration's effort to cut red tape

New proposed rules released today by the Centers for Medicare & Medicaid Services would reduce unnecessary, obsolete, or burdensome regulations and save hospitals and healthcare providers nearly \$1.1 billion each year and over \$5 billion over 5 years. The new proposals regarding the rules for hospitals that treat Medicare and Medicaid patients were developed in response to President Obama's call on all Federal agencies to eliminate burdensome and unnecessary regulations.

"The President and I have challenged agencies to hunt down burdensome regulations," said Vice President Joe Biden. "Today's steps will remove outdated, duplicative, unnecessary burdens on hospitals - saving money and improving care."

"President Obama has been clear: it's time to cut the red tape," said HHS Secretary Kathleen Sebelius. "Our new proposals eliminate unnecessary and obsolete standards and free up resources so hospitals and doctors can focus on treating patients."

CMS proposed two sets of regulatory reforms today, and finalized a third. All are designed to improve transparency and help providers operate more efficiently by reducing their regulatory burden. One set proposes to update the rules for hospitals that treat Medicare and Medicaid patients -- the Medicare Conditions of Participation. As an example, the proposed reforms would consolidate patient care plans and eliminate outdated requirements for hospital management. This could save hospitals over \$900 million per year and perhaps grow to much more over time as hospitals increasingly use this new flexibility.

The second set of reforms address regulatory requirements for providers other than hospitals and could save up to \$200 million in the first year. The rule would identify and begin to eliminate duplicative, overlapping, outdated, and conflicting regulatory requirements for healthcare providers and suppliers such as end-stage renal disease facilities and durable medical equipment suppliers. Examples of these reforms include updating obsolete e-prescribing technical requirements to meet current standards and eliminating other out-of-date and overly prescriptive requirements for healthcare providers.

CMS is also finalizing a third rule that reduces regulatory burden for ambulatory surgical centers (ASCs), which is expected to save ASCs \$50 million per year. This rule makes common-sense changes to the requirements ASCs must follow in order to meet Medicare and Medicaid health and safety standards.

These regulatory reforms are just one part of a wide-ranging effort by the Obama Administration to improve the quality of health care and lower costs for all Americans, using important new tools provided by the Affordable Care Act. These efforts include the National Quality Strategy and the Partnership for Patients. These initiatives aim to reform the health care delivery system and bring together both private and public sector partners to keep patients from getting injured or sicker in the health care system and to improve transitions between care settings. CMS intends to invest up to \$1 billion to help drive these

changes through the Partnership for Patients initiative. And beginning in FY 2013, for the first time, the Hospital Value-Based Purchasing program authorized by the Affordable Care Act will pay hospitals' inpatient acute care services based partially on care quality, not just the quantity of the services they provide.

To view the proposed and final rules, please visit: www.ofr.gov/inspection.aspx.

Both proposals invite the public, including doctors, hospitals, patient advocates, and other stakeholders, to comment. To submit a comment, visit www.regulations.gov, enter the ID number CMS-9070-P or CMS-3244-P, and click on "Submit a Comment."

For additional information on these and other Conditions of Participation, visit http://www.cms.gov/CFCsAndCoPs/01_Overview.asp

For additional information on the Department of Health and Human Services overall Plan for Retrospective Review of Existing Rules, visit http://www.hhs.gov/open/execorders/13563/hhs_final_retrospective_review_plan_8-19-11_4.pdf.

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Note: All HHS press releases, fact sheets and other press materials are available at <http://www.hhs.gov/news>.



FACT SHEET

FOR IMMEDIATE RELEASE
October 18, 2011

Contact: CMS Media Relations Group
(202) 690-6145

Reduced Medicare regulatory burdens for healthcare providers would save nearly \$1.1 billion

On October 18, the Centers for Medicare & Medicaid Services (CMS) took steps to reduce unnecessary, obsolete, or burdensome regulations on American hospitals and healthcare providers. These steps would help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and would save nearly \$1.1 billion across the health care system in the first year for a total of over \$5 billion over 5 years.

CMS proposed two sets of regulatory reforms today, and finalized a third. All are designed to improve transparency and help providers operate more efficiently by reducing their regulatory burden. One set proposes updates to the Medicare Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs). The second set addresses regulatory requirements for a broader range of health care providers and suppliers who are regulated under Medicare and Medicaid. CMS also finalized a third rule reducing regulatory burden for ambulatory surgical centers (ASCs).

CMS estimates that annual savings to hospitals from the proposed revisions to the Conditions of Participation could exceed \$900 million in its first year as hospitals increasingly use this new flexibility. The Medicare Regulatory Reform rule could save up to \$200 million in the first year. The final rule for ASCs could generate an extra \$50 million in savings per year.

Taken together, these three rules would reduce hospital and other healthcare provider costs by nearly \$1.1 billion the first year. These cost savings would come directly from reduced regulatory burdens, and are not accompanied by reimbursement reductions. As such, all of these savings would be available to help providers improve the quality of care they provide to Medicare beneficiaries and all Americans.

Background

The proposed rules were developed through a retrospective review of existing regulations called for by President Obama's January 18, 2011 Executive Order 13563, to "modify, streamline, or

repeal” regulations which impose unnecessary burdens, including on hospitals and other providers that must comply with requirements under Medicare.

The rules take into consideration numerous burden reduction recommendations from hospitals, critical access hospitals, and patient advocates, among others.

Medicare Conditions of Participation

The Conditions of Participation are federal health and safety requirements ensuring high quality care for all patients. Hospitals and critical access hospitals must meet these conditions to participate in the Medicare and Medicaid programs. The proposed rule is designed to reduce the regulatory burden on hospitals by the following:

- Eliminating burdensome requirements that do not permit hospital patients or their caregivers/support persons to administer certain medications.
- Allowing hospitals to determine the best ways to oversee and manage outpatients by removing the unnecessary requirement for a single Director of Outpatient Services.
- Increasing flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system.
- Enabling hospitals to have a single, interdisciplinary care plan that supports coordination of care instead of requiring a separate stand-alone nursing care plan.
- Allowing CAHs to provide certain services, including laboratory and radiology services, under arrangement.

Medicare Regulatory Reform

The Medicare Regulatory Reform rule would identify and begin to eliminate duplicative, overlapping, outdated, and conflicting regulatory requirements for health care providers and suppliers, including hospitals, ambulatory surgical centers, end-stage renal disease facilities, durable medical equipment suppliers, and a host of other healthcare providers and suppliers regulated under Medicare and Medicaid. The goal of this proposed rule is to both reduce regulatory burdens and help providers improve care for patients.

This rule would help reduce unnecessary burdens on health care providers, allowing them to dedicate more resources to improving patient care. Some of the more than two dozen proposed regulatory changes include:

- Eliminating obsolete regulations, including expired OMB paperwork control numbers; outmoded infection control instructions for Ambulatory Surgical Centers; outdated Medicaid qualification standards for physical and occupational therapists; and duplicative requirements for governing bodies of Organ Procurement Organizations.
- Clarifying which higher risk End Stage Renal Disease (ESRD) facilities are required to comply with the full federal Life Safety Code requirements. CMS estimates that this burden reduction could save an estimated \$108.7 million for the ESRD program.
- Eliminating the current Medicare requirement that automatically deactivates a provider or supplier who has not submitted a claim for 12 consecutive months, keeping providers from

inadvertently being barred from re-enrolling in Medicare for a certain period. Savings from this regulatory reform are projected to be \$26.7 million annually.

- Eliminating the specific list of emergency equipment Ambulatory Surgical Centers must have on hand, and allowing facilities, in conjunction with medical staff and their governing bodies, to develop policies and procedures that specify emergency equipment appropriate to the services they provide.
- Replacing inflexible time-limited agreements which govern Intermediate Care Facilities for the Mentally Retarded participation in Medicaid, with open-ended agreements and reducing states' paperwork burden by requiring inspection of these facilities once a year. The regulation also takes up a recommendation from stakeholders to replace the term "mental retardation" with the term "intellectual disability," which has gained wide public acceptance in recent years.
- Updating e-prescribing technical requirements so Medicare Prescription Drug Plans meet current standards.

Regulatory Reform for Ambulatory Surgical Centers

Today's announcement also includes a final rule from CMS that would update the conditions for coverage regulations for Ambulatory Surgical Centers (ASCs), based on a proposed rule CMS issued in April 2010.

This new final rule simplifies requirements that ASCs must follow in notifying patients about their rights. Specifically, the final rule will allow ASCs to provide the patient, the patient's representative, or the patient's surrogate with patient rights information prior to the start of the surgical procedure. Before today's final rule, ASCs were required to notify patients in advance of the date of the procedure. This caused particular logistical problems and inconveniences for patients who needed ASC services on the same day they received a physician referral.

For More Information

To view the proposed rules, please visit www.ofr.gov/inspection.aspx. To submit a comment, visit www.regulations.gov, enter the ID number CMS-9070-P or CMS-3244-P, and click on "Submit a Comment."

For additional information on hospital and critical access hospital Conditions of Participation, visit http://www.cms.gov/CFCsAndCoPs/06_Hospitals.asp

The proposed rule also invites public comment on a broad range of recommendations to improve patient safety and hospital quality of care beyond those specified in the Conditions of Participation.

CMS' final rule on Ambulatory Surgery Centers will be effective on Tuesday, October 18, 2011. More information about ASCs is online at http://www.cms.gov/CFCsAndCoPs/16_ASC.asp.

The Department of Health and Human Services also has launched the *Partnership for Patients* initiative, a national collaboration with hospitals, employers, physicians, nurses, patient advocates, and State governments to protect patient safety, provide better care, and reduce costs. For more about the Partnership for Patients, go to:
<http://www.healthcare.gov/center/programs/partnership/index.html>

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 19 Dec 2011 13:36:27 -0500
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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Announces Selection of 32 Pioneer Accountable Care Organizations

Attachments: Pioneer Press ReleaseFINAL.PDF, Pioneer Descriptions_Dec 19_FINAL.PDF, 11 12 19 FINAL pioneer general fact sheet.pdf, 11 12 19 FINAL pioneer bene rights fact sheet.pdf

U.S. House and Senate Notification

Monday, December 19, 2011

To: Congressional Health Staff

From: Jennifer Boulanger
Acting Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: HHS Announces Selection of 32 Pioneer Accountable Care Organizations

Today, the Department of Health and Human Services (HHS) announced the selection of 32 organizations to participate in the Pioneer Accountable Care Organization (ACO) initiative.

Under this initiative, operated by the Centers for Medicare & Medicaid Services (CMS) Innovation Center, Medicare will reward groups of health care providers that have formed ACOs based on how well they are able to both improve the health of their Medicare patients and lower their health care costs. Selected Pioneer ACOs include organizations in various geographic regions of the country, representing 18 states and the opportunity to improve care for 860,000 Medicare beneficiaries. Estimates by the CMS Office of the Actuary suggest the program will help Medicare save up to \$1.1 billion over five years by better coordinating patient care.

Please find attached a press release and fact sheets regarding this announcement, including the final list of participating Pioneer ACOs, and more information about the Pioneer ACO Model and Medicare beneficiary rights in an ACO. These materials are also available online at:
<http://innovations.cms.gov/initiatives/aco/pioneer>.

The Pioneer ACO Model is one of several initiatives underway at CMS designed to encourage the formation of ACOs. For more information, visit www.cms.gov/aco.

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220. Thank you.



FOR IMMEDIATE RELEASE

Monday, December 19, 2011

Contact: HHS Press Office

(202) 690-6343

Affordable Care Act helps 32 health systems improve care for patients, saving up to \$1.1 billion
Leading health care providers will be Pioneer Accountable Care Organizations

Thirty-two leading health care organizations from across the country will participate in a new Pioneer Accountable Care Organizations (ACOs) initiative made possible by the Affordable Care Act, HHS Secretary Kathleen Sebelius announced today. The Pioneer ACO initiative will encourage primary care doctors, specialists, hospitals and other caregivers to provide better, more coordinated care for people with Medicare and could save up to \$1.1 billion over five years.

Under this initiative, operated by the Centers for Medicare & Medicaid Services (CMS) Innovation Center (Innovation Center), Medicare will reward groups of health care providers that have formed ACOs based on how well they are able to both improve the health of their Medicare patients and lower their health care costs.

“Pioneer ACOs are leaders in our work to provide better care and reduce health care costs,” said Secretary Sebelius. “We are excited that so many innovative systems are participating in this exciting initiative – and there are many other ways that health care providers can get involved and help improve care for patients.”

The Pioneer ACO initiative is just one of a menu of options for providers looking to better coordinate care for patients and use health care dollars more wisely. The Pioneer ACO model is designed specifically for groups of providers with experience working together to coordinate care for patients. The Medicare Shared Savings Program and the Advance Payment ACO Model, both announced in October 2011, are also ACO options for providers. More information about the full menu of options for providers and how to apply to participate is available [here](#).

“We know that health care providers are at different stages in their work to improve care and reduce costs,” said Marilyn Tavenner, acting Administrator of CMS. “That’s why we’ve developed a menu of options for Medicare to meet doctors, hospitals, and other healthcare providers where they are, and begin the conversation of how to enhance the care they are offering to people with Medicare.”

The 32 Pioneer ACOs underwent a rigorous competitive selection process by the Innovation Center, including extensive review of applications and in-person interviews.

The initiative will test the effectiveness of several innovative payment models and how they can help experienced organizations to provide better care for beneficiaries, work in coordination with private payers, and reduce Medicare cost growth. These payment models will allow organizations that are successful in achieving better care and lower cost growth to move away from a payment system based on volume under the fee-for-service model, towards one where the ACO is paid based on the value of care it provides.

The Pioneer ACO model requires ACOs to engage other payers in similar efforts to reward health care providers that deliver high-quality care. The Pioneer ACO model also includes strict beneficiary protections, including the ability for patients to seek care from any Medicare provider they wish.

Selected Pioneer ACOs include physician-led organizations and health systems, urban and rural organizations, and organizations in various geographic regions of the country, representing 18 States and the opportunity to improve care for about 860,000 Medicare beneficiaries.

The first performance period of the Pioneer ACO Model will begin January, 1st 2012.

For the final list of participating Pioneer ACOs and more information about the Pioneer ACO Model, a fact sheet is posted at https://www.cms.gov/apps/media/fact_sheets.asp or you can visit: <http://innovations.cms.gov/initiatives/aco/pioneer>

The Pioneer ACO Model is one of several initiatives underway at CMS designed to support the formation of ACOs. For more information, visit www.cms.gov/aco.

For more information about the CMS Innovation Center, visit innovations.cms.gov.

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Note: All HHS press releases, fact sheets and other press materials are available at <http://www.hhs.gov/news>.



Selected Participants in the Pioneer ACO Model
December 19, 2011

The Pioneer Accountable Care Organization (ACO) Model is a CMS Innovation Center initiative designed to support organizations with a new payment model, allowing them to provide more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model will test the impact of several innovative payment arrangements to support these organizations in achieving the goals of better care and outcomes at a lower cost.

The Pioneer ACO Model was designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements. The selected organizations were chosen for their significant experience offering this type of quality care to their patients, along with other criteria listed in the Request for Applications (RFA) document available at www.innovations.cms.gov. These organizations were selected through an open and competitive process from a large applicant pool that included many qualified organizations.

This document provides brief descriptions of the 32 organizations selected to participate in the Pioneer ACO Model.

Description of Selected ACOs

The descriptions of selected ACOs provided in this document are based on information provided by the ACOs for publication and do not necessarily reflect the views of CMS.

Organizations participating in the Pioneer ACO Model:

Organization	Service Area
1. Allina Hospitals & Clinics	Minnesota and Western Wisconsin
2. Atrius Health Services	Eastern and Central Massachusetts
3. Banner Health Network	Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)
4. Bellin-Thedacare Healthcare Partners	Northeast Wisconsin

The descriptions of selected ACOs provided in this document are based on information provided by the ACOs for publication and do not necessarily reflect the views of CMS.

5. Beth Israel Deaconess Physician Organization	Eastern Massachusetts
6. Bronx Accountable Healthcare Network (BAHN)	New York City (the Bronx) and lower Westchester County, NY
7. Brown & Toland Physicians	San Francisco Bay Area, CA
8. Dartmouth-Hitchcock ACO	New Hampshire and Eastern Vermont
9. Eastern Maine Healthcare System	Central, Eastern, and Northern Maine
10. Fairview Health Systems	Minneapolis, MN Metropolitan Area
11. Franciscan Health System	Indianapolis and Central Indiana
12. Genesys PHO	Southeastern Michigan
13. Healthcare Partners Medical Group	Los Angeles and Orange Counties, CA
14. Healthcare Partners of Nevada	Clark and Nye Counties, NV
15. Heritage California ACO	Southern, Central, and Costal California
16. JSA Medical Group, a division of HealthCare Partners	Orlando, Tampa Bay, and surrounding South Florida
17. Michigan Pioneer ACO	Southeastern Michigan
18. Monarch Healthcare	Orange County, CA
19. Mount Auburn Cambridge Independent Practice Association (MACIPA)	Eastern Massachusetts
20. North Texas Specialty Physicians	Tarrant, Johnson and Parker counties in North Texas
21. OSF Healthcare System	Central Illinois
22. Park Nicollet Health Services	Minneapolis, MN Metropolitan Area
23. Partners Healthcare	Eastern Massachusetts
24. Physician Health Partners	Denver, CO Metropolitan Area
25. Presbyterian Healthcare Services – Central New Mexico Pioneer Accountable Care Organization	Central New Mexico
26. Primecare Medical Network	Southern California (San Bernadino and Riverside Counties)
27. Renaissance Medical Management Company	Southeastern Pennsylvania
28. Seton Health Alliance	Central Texas (11 county area including Austin)
29. Sharp Healthcare System	San Diego County
30. Steward Health Care System	Eastern Massachusetts
31. TriHealth, Inc.	Northwest Central Iowa
32. University of Michigan	Southeastern Michigan

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Allina Hospitals & Clinics

Classification: Integrated Delivery System

Service Area: Minnesota and Western Wisconsin

Allina Hospitals & Clinics is a not-for-profit system of hospitals, clinics and health care services, providing care throughout Minnesota and western Wisconsin. Allina owns and operates 11 hospitals, more than 90 clinics and specialty care centers, and specialty medical services that provide hospice care, oxygen and home medical equipment, pharmacies, and emergency medical transportation services.

Organizations affiliated with Allina include:

Hospitals: Abbott Northwestern Hospital, Buffalo Hospital, Cambridge Medical Center, Mercy Hospital, New Ulm Medical Center, Owatonna Hospital, Phillips Eye Institute, River Falls Area Hospital, St. Francis Regional Medical Center (jointly owned), United Hospital, Unity Hospital.

Ambulatory care centers: Abbott Northwestern's Center for Outpatient Care, Edina, Elk Ridge Health, WestHealth Campus and Woodbury Ambulatory Surgery Center (jointly owned)

Clinic groups (multiple locations): Allina Medical Clinic, Aspen Medical Group, Quello Clinic. Multiple hospital-based clinics.

The descriptions of selected ACOs provided in this document are based on information provided by the ACOs for publication and do not necessarily reflect the views of CMS.

Atrius Health Services

Classification: Medical Group Practice

Service Area: Eastern Massachusetts

Atrius Health, a nonprofit alliance of six multi-specialty medical groups, was created in 2004 to enable collaboration on new and better ways of delivering care while maintaining an emphasis on care for the local community. The 1000 physicians and over 1425 other healthcare professionals in these groups serve almost 1,000,000 adult and pediatric patients from about 50 sites across Eastern and Central Massachusetts. The Atrius Health Pioneer ACO comprises five medical groups: Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates, South Shore Medical Center, and Southboro Medical Group.

The Atrius Health groups work closely with academic medical centers and community hospitals to coordinate care across the continuum for their patients. The Atrius Health groups have implemented advanced use of health information technology (including a patient portal for secure electronic communication), chronic disease management, clinical pharmacy programs, Lean care improvement, and innovative ways of delivering care such as shared medical appointments.

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Banner Health Network

Classification: Integrated Delivery System

Service Area: Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)

The Banner Health Network (BHN) has been designed to provide a highly coordinated patient care experience to Medicare patients who will be served by this integrated network. BHN comprises Banner Health-affiliated physicians, 13 acute-care Banner hospitals (12 in the Phoenix metro area) and other Banner services in Arizona. Nonprofit Banner Health is Arizona's largest health care provider. The network will ensure convenient access to Medicare patients with more than 2,600 private and employed physicians located throughout Maricopa County and into Pinal County.

BHN is a comprehensive provider network that accepts patient care and financial accountability for those served by the network. It is one of a few networks in Arizona serving patients in a population health management model. This model offers a highly coordinated patient experience through a primary care setting that seeks to improve patient outcomes, provide more effective management of chronic care and emphasize wellness. A key result of this patient-centered model will be higher efficiency that will result in improved control of costs. A foundation of the Banner Health Network's ability to deliver highly coordinated and integrated patient care is an enhanced electronic medical records system that is utilized in all Banner hospitals.

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Bellin-ThedaCare Healthcare Partners

Classification: Integrated Delivery System

Service Area: Northeast Wisconsin

Bellin – ThedaCare Healthcare Partners is an organization of providers covering 12 counties in Northeast Wisconsin. Two leading healthcare systems; Bellin Health, based in Green Bay and ThedaCare, based in Appleton, as well as eight major health care facilities, and nearly 700 physicians make up the network.

Originally named the Northeast Wisconsin Health Value Network, Bellin – ThedaCare Healthcare Partners was formed in 2008 to create value through quality improvement, efficiency of care and an approach to care that emphasizes life-long health. Those participating in the network coordinate patient care and maintain a centralized electronic medical record. Through coordination, information sharing and following a program of continuous incremental improvement, Bellin-ThedaCare enables healthcare providers to achieve desired clinical outcomes in a cost effective manner, achieve greater overall health for our patients and foster a positive relationship with employers and purchasers. For the benefit of purchasers, patients and physicians, Bellin-ThedaCare issues regular report cards that track actual performance based on a strict set of criteria. This report card ensures ongoing quality improvement.

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Beth Israel Deaconess Physician Organization

Classification: Network of Independent Practice Associations

Service Area: Eastern Massachusetts

Beth Israel Deaconess Physician Organization, LLC (“BIDPO”) is a provider network /IPA-model physician organization of over 1600 physicians including 400 primary care physicians. BIDPO spans a wide geography with over 125 primary care practice locations. Our practices include small, mid and large practices located throughout eastern Massachusetts, north from the New Hampshire border and south to Cape Cod. BIDPO promotes the highest quality of coordinated, cost effective patient care and safety through our managed care services and medical management programs.

BIDPO is affiliated with Beth Israel Deaconess Medical Center, Inc., (“BIDMC”) a major teaching affiliate of Harvard Medical School in Boston, MA. BIDPO physicians are also affiliated with community hospitals that serve their regions including the hospitals affiliated with BIDMC: Beth Israel Deaconess Needham, Milton, Lawrence General and Anna Jaques Hospitals.

The descriptions of selected ACOs provided in this document are based on information provided by the ACOs for publication and do not necessarily reflect the views of CMS.

Bronx Accountable Healthcare Network (BAHN)

Classification: Partnership of an integrated delivery system and an Independent Practice Association (IPA)

Service Area: New York City (Bronx) and lower Westchester County, NY

The Bronx Accountable Healthcare Network (BAHN), a not-for-profit independent practice association, is a Pioneer ACO sponsored by Montefiore Medical Center, an integrated delivery system of four hospitals, 22 primary care sites and a home care agency serving the Bronx and lower Westchester County in New York.

The BAHN's Board includes Montefiore executives and physicians and consumer advocate and patient representation. The BAHN will contract with the Montefiore IPA to provide care and with CMO, Montefiore's care management company, for care management services. The Montefiore IPA includes nearly 2,400 employed and independent physicians plus allied health professionals and ancillary care providers. CMO has fifteen years of experience providing medical and behavioral care management services for health plans and currently manages close to \$800 million in capitation for more than 140,000 lives.

Montefiore is the largest health care provider serving the Bronx, one of the poorest, most disease-burdened and ethnically and racially diverse urban counties in the US. It is one of the nation's largest academic medical centers and the University Hospital for the Albert Einstein College of Medicine.

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Brown & Toland Physicians

Classification: Independent Practice Association (IPA)

Service Area: San Francisco Bay Area, CA

Brown & Toland Physicians is an independent practice association (IPA) of more than 1,500 physicians serving more than 335,000 HMO and PPO patients. Owned and governed by physicians, and based in San Francisco, Brown & Toland provides care for patients across the Bay Area. The group has earned numerous awards for quality and innovation, and has been named a California Association of Physician Groups (CAPG) “Elite” group for five consecutive years. In August 2011, Brown & Toland announced an affiliation with Emeryville, California’s Alta Bates Medical Group.

Brown & Toland currently is participating in an accountable care organization project with Blue Shield and California Pacific Medical Center caring for more than 21,000 San Francisco City and County employees, and is exploring additional ACO opportunities with health care partners. The group’s overriding objective is to improve the methods of delivery and health of beneficiaries, and to reduce the cost of care. For more information about Brown & Toland, visit www.browndtoland.com.

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Dartmouth-Hitchcock ACO

Classification: Integrated Delivery System
Service Area: New Hampshire and Eastern Vermont

The Dartmouth-Hitchcock ACO ("DH") is an integrated healthcare delivery system comprising Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic. DH serves patient populations from throughout New Hampshire and eastern Vermont. DH previously participated in both the CMS Physician Group Practice Demonstration Project and the Transition Demonstration Project. Participation in the Pioneer ACO Model will continue DH's commitment to population health management utilizing its already established Primary Care Medical Home Practice Model throughout its organization. Concurrently, DH is working to develop supportive data and clinical information systems, in collaboration with other healthcare organizations, to further enhance its work in creating value for the population it serves.

The descriptions of selected ACOs provided in this document are based on information provided by the ACOs for publication and do not necessarily reflect the views of CMS.

Eastern Maine Healthcare Systems

Classification: Integrated Delivery System

Service Area: Central, Eastern, and Northern Maine

Eastern Maine Healthcare Systems (EMHS) is an integrated health delivery system with nearly 8,000 employees, seven member hospitals, three affiliated hospitals, multiple integrated physician groups, long-term care and home health companies, emergency transport teams, and a number of other organizations that support the health delivery system for the northern two-thirds of Maine. EMHS serves central, eastern, and northern Maine - approximately 70% of the land mass in the State of Maine and more than 40% of the state's residents.

EMHS' Pioneer ACO includes three of the system's member hospitals; Eastern Maine Medical Center, The Aroostook Medical Center, and Inland Hospital. As a Beacon Community funded by the Office of the National Coordinator for Health Information Technology, EMHS will also continue to work closely with Beacon partners St. Joseph Hospital, Penobscot Community Health Care, and others.

EMHS embraces organizations that share the system's community health mission. Collaborative efforts are occurring with other healthcare systems both within the EMHS service area and statewide. Additional efforts are underway with major employers and the Maine Health Management Coalition. The overall goal is to evolve healthcare from a system that rewards us for doing more, to a system that rewards us for keeping people healthy.

The descriptions of selected ACOs provided in this document are based on information provided by the ACOs for publication and do not necessarily reflect the views of CMS.

Fairview Health Services

Classification: Integrated Delivery System

Service Area: Minneapolis, MN Metropolitan area

Based in Minneapolis, Fairview Health Services is a non-profit health care system providing the full continuum of clinical care—from prevention of illness and injury to care for the most complex medical conditions. Fairview Health Network, part of Fairview Physician Associates (FPA), brings together Fairview-employed providers and independent providers who are committed to delivering higher value to patients and payers. Fairview and FPA will partner in the Pioneer ACO Model to deliver great care and better value to Medicare patients.

Participating primary care providers will work with other providers and specialists including Fairview-employed physicians, affiliated academic physicians within University of Minnesota Physicians and aligned independent physicians within FPA. Providers can also access Fairview's broad continuum of care. Fairview includes 40-plus primary care clinics, a wide range of specialty services, home care, senior service and seven hospitals, including the University of Minnesota Medical Center, Fairview. In partnership with the University of Minnesota, Fairview is an academic health system striving to enhance the clinical enterprise, achieve nation-leading research and academic prominence.

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Franciscan Health System

Classification: Integrated Delivery System

Service Area: Indianapolis and Central Indiana

Franciscan Alliance is one of the largest Catholic healthcare systems in the Midwest, consisting of 14 hospitals serving Indiana and Illinois communities for over 135 years. An integral part of this large healthcare system is the Franciscan Alliance Accountable Care Organization (ACO) Central Indiana Region, which is a quality focused, clinically integrated network of providers serving the greater Indianapolis MSA and Central Indiana area. The ACO includes acute care and critical access hospitals, physician groups, federally qualified health centers, ambulatory surgery centers, home health agencies and other healthcare providers. This collaborative, interdisciplinary healthcare team has allowed the Franciscan Alliance ACO to develop a model of care that improves the health outcomes and satisfaction of patients served throughout Central Indiana.

For more information on Franciscan Alliance go to www.14hospitals.org.

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Genesys PHO

Classification: Partnership of hospital system and medical practices

Service Area: Southeastern Michigan

Genesys PHO is collaboration between Genesys Health System and 160 primary care physicians with 400 participating specialist physicians who deliver health care services in Genesee, Lapeer, Shiawassee, Tuscola and northern Oakland counties. Genesys PHO and/or its participating providers focus on the personal relationship with the patients and their families and have been recognized nationally, state-wide, and locally for the quality of care that the patients receive and the improvements to the population of patients its participating providers serve.

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HealthCare Partners Medical Group

Classification: Independent Practice Association (IPA)
Service Area: Los Angeles and Orange Counties, California

HealthCare Partners Medical Group (HealthCare Partners) is a multispecialty medical group and independent practice association (IPA) serving Los Angeles and Orange counties. HealthCare Partners has been named a top-performing medical group for eight years in a row by the not-for-profit Integrated Healthcare Association (IHA) based on clinical excellence, patient experience, use of information technology, and coordinated diabetes care.

Since its founding in 1992, HealthCare Partners has grown significantly, becoming one of the largest physician groups in the nation. The group currently serves over 700,000 patients, who can access care from more than 1,200 primary care physicians in 900 locations. Primary care physicians are supported by more than 3,000 specialists. HealthCare Partners-affiliated doctors speak the languages of the diverse communities they serve.

Besides medical offices, HealthCare Partners owns and operates urgent care centers, walk-in clinics, and ambulatory surgery centers. In addition to the Pioneer ACO Model, HealthCare Partners also participates in the Brookings-Dartmouth Commercial ACO.

For more information, please visit www.healthcarepartners.com

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HealthCare Partners of Nevada

Classification: Independent Practice Association (IPA)

Service Area: Clark and Nye counties, NV

HealthCare Partners of Nevada is a multispecialty medical group and independent practice association (IPA) serving Clark and Nye counties. Since its founding in 1997, HealthCare Partners of Nevada has grown significantly, becoming one of the largest physician groups in Nevada. The group currently serves over 31,000 managed care patients, who can access care from more than 203 primary care physicians in 102 locations. Primary care physicians are supported by more than 1,700 specialists. HealthCare Partners of Nevada-affiliated doctors speak the languages of the diverse communities they serve.

In addition to medical offices, HealthCare Partners of Nevada owns and operates urgent care centers and walk-in clinics. HealthCare Partners of Nevada has long-standing partnerships with a broad network of hospitals, skilled nursing facilities, ambulatory surgery centers, and other ancillary healthcare organizations. HealthCare Partners of Nevada has also developed disease management programs that assist patients in managing their health conditions along with their healthcare team.

For more information, please visit www.hcpnv.com

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Heritage California ACO

Classification: Independent Practice Associations (IPA)

Service Area: Southern, Central and Coastal California

Heritage California ACO is operated by the Heritage Provider Network (HPN) family of organizations which was founded in 1979 by Dr. Richard Merkin, President and CEO. The HPN Network is comprised of Heritage Provider Network, Inc. and its ten affiliated Medical Groups and Independent Practice Associations (IPA) which operate throughout eight counties in Southern, Central and Coastal California, spanning San Luis Obispo and Tulare Counties to the North, Orange County to the South, Riverside and San Bernardino Counties to the East, and the entire Los Angeles basin.

HPN has been voted a top 10 provider delivery network by the California Association of Physician Groups and is one of the largest multi-specialty medical groups in California. HPN delivers high quality, patient centered health care to over 700,000 individuals, and through its provider network contracts with 2,300 primary care physicians, 30,000 specialist physicians and over 100 hospitals.

Heritage California ACO will demonstrate that a fully integrated patient-focused, physician-directed and care coordinated program will improve quality and reduce healthcare per capita spending.

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JSA Medical Group

Classification: Independent Practice Association (IPA)
Service Area: Orlando, Tampa Bay, and South Florida

JSA Medical Group (JSA), a division of HealthCare Partners, is a primary care medical group and independent practice association (IPA) serving the Orlando, Tampa Bay, and South Florida areas. Since its founding in 1969, JSA has grown significantly, becoming one of the largest physician groups in Florida. The group currently serves over 46,000 managed care patients, who can access care from 184 primary care physicians in 96 locations. Primary care physicians are supported by nearly 1,800 specialists. JSA-affiliated doctors speak the languages of the diverse communities they serve.

In addition to medical offices, JSA has partnerships with local area hospitals. JSA has received National Committee for Quality Assurance (NCQA) Level 3 certification (the highest level of certification) for 21 medical offices as patient centered medical homes. JSA has also developed disease management programs that assist patients in managing their health conditions.

For more information, please visit www.jsahealthcare.com

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Michigan Pioneer ACO

Classification: Partnership of hospital system and medical practices

Service Area: Southeastern Michigan, primarily tri-county Detroit metropolitan area

The Michigan Pioneer ACO is a partnership of The Detroit Medical Center and its physicians, who include employed and faculty physicians, but consisting mostly of private practice primary care physicians. The Detroit Medical Center is an academically integrated system in metropolitan Detroit and one of the largest health care providers in southeast Michigan. The Michigan Pioneer ACO's primary service area consists of the tri-county Detroit metropolitan area (i.e., Wayne, Oakland and Macomb Counties).

DMC is part of Vanguard Health Systems. The DMC serves as a teaching and clinical research site for Wayne State University School of Medicine. Michigan Pioneer ACO will be managed by the DMC PHO, an 1100 member physician-hospital organization. DMC is affiliated with the Barbara Ann Karmanos Cancer Center and the Kresge Eye Center.

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Monarch Healthcare

Classification: Independent Practice Association (IPA)

Service Area: Orange County, CA

Monarch HealthCare is a physician-led Independent Practice Association (“IPA”). Formed in 1994, it is the largest physician organization providing care throughout Orange County, California, and the only one with a county-wide presence. Monarch contracts with over 2,300 independent, private-practice physicians to provide health care for approximately 172,000 commercial, Medicare, and Medicaid managed care patients. For the Pioneer ACO Model, Monarch has selected an initial subset of 270 physicians for participation. In 2007, Monarch formed Monarch Health Plan, a California-licensed health plan bearing full risk for over 11,000 Medicare Advantage beneficiaries.

Monarch was selected by the Engelberg Center for Health Care Reform at Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice in 2010 to be one of their five selected sites nationally to participate in a five-year ACO pilot program for commercial PPO patients.

Monarch is committed to advancing medical excellence and exemplifying the “patient-first” philosophy of healthcare. For more information, please visit www.monarchhealthcare.com.

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Mount Auburn Cambridge Independent Practice Association (MACIPA)

Classification: Independent Practice Association (IPA)

Service Area: Eastern Massachusetts

Mount Auburn Cambridge Independent Practice Association (MACIPA) is an independent practice association established in 1985. MACIPA is comprised of over 500 physicians, and its service area includes Cambridge, Arlington, Watertown, Belmont, Somerville, Lexington, Waltham, and Medford, Massachusetts. Physician members of MACIPA include doctors in private practice and those employed by Mount Auburn Hospital and the Cambridge Health Alliance. Practices range from solo physicians to groups of approximately 25 physicians. MACIPA works in collaboration with Mount Auburn Hospital, and together they have a long history of innovation in healthcare, quality improvement and care coordination. Mount Auburn Hospital, a Harvard teaching hospital based in Cambridge, Massachusetts, combines community hospital and teaching hospital services emphasizing excellence with compassionate care.

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North Texas ACO

Classification: Partnership of health system and Independent Physician Association (IPA)
Service Area: Tarrant, Johnson and Parker counties in North Texas

North Texas Specialty Physicians (NTSP) is an independent practice association comprising nearly 600 family and specialty doctors caring for residents of Tarrant, Johnson and Parker counties in North Texas. NTSP has more than 10 years experience with population health management on a risk basis, sharing financial risk with the Centers for Medicare and Medicaid Services (CMS) through Medicare Advantage, based on patient outcomes.

Texas Health Resources is one of the largest faith-based, nonprofit health systems in the country, serving 16 counties in North Texas comprising more than 6.2 million people. The health system includes 24 acute care and short-stay hospitals that are owned, operated, joint-ventured or affiliated with Texas Health Resources. It includes the Texas Health Presbyterian, Texas Health Arlington Memorial and Texas Health Harris Methodist hospitals, a large physician group, outpatient facilities, and home health, preventive and fitness services, and an organization for medical research and education. Texas Health has participated in several CMS initiatives, including the Hospital Quality Incentive Demonstration.

NTSP and Texas Health have worked together for many years to improve the quality, safety and efficiency of care for patients. For example, Texas Health has been a primary participant in developing the NTSP health information exchange, known as Sandlot.

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OSF Healthcare System

Classification: Integrated Delivery System

Service Area: Central Illinois

OSF provides state-of-the-art, compassionate care to more than 3.7 million people in its communities. OSF HealthCare is a multi-state corporation operating facilities in Illinois and Michigan. In 2011 OSF HealthCare was ranked 25th among 600 Integrated Health Care Networks in the U.S. by SDI Health.

OSF HealthCare is owned and operated by The Sisters of the Third Order of St. Francis in Peoria, Illinois. OSF HealthCare includes OSF Healthcare System, with seven hospitals, one long-term care facility and two colleges of nursing. Also included is OSF Medical Group with more than 650 member physicians and advanced care practitioners in 90 locations. OSF owns an extensive network of home health services known as OSF Home Care Services and also owns OSF Saint Francis, Inc., comprised of health care-related businesses, and OSF Healthcare Foundation. The OSF Healthcare System Pioneer ACO includes only those facilities, services and programs available in Central Illinois.

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Park Nicollet Health Services

Classification: Integrated Delivery System
Service Area: Minneapolis/St. Paul metropolitan area

Park Nicollet Health Services is an integrated health care system based in St. Louis Park, Minnesota that includes Park Nicollet Methodist Hospital, Park Nicollet Clinic, Park Nicollet Foundation and Park Nicollet Institute. Park Nicollet has more than 8,100 employees and more than 1,000 physicians on staff. Park Nicollet is also one-third owner of St. Francis Regional Medical Center in Shakopee, Minnesota. Park Nicollet serves the Minneapolis/St. Paul metropolitan area and its suburbs through Methodist Hospital and a system of neighborhood primary care clinics and specialty centers that include heart and vascular care, orthopaedic care, cancer, Parkinson's and eating disorders treatment. Park Nicollet provides care in more than 50 medical specialties.

Park Nicollet Methodist Hospital was named one of Thomson Reuters' 50 Top Cardiovascular Hospitals in the country in 2012 – the 8th consecutive year Park Nicollet has received this designation. Park Nicollet participated in CMS's Physician Group Practice (PGP) Demonstration Project, Medicare's first pay-for-performance initiative that established incentives for quality improvement and cost efficiency at the level of physician group practices. Park Nicollet completed the PGP project and has participated in the PGP Transition Demonstration.

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Partners HealthCare

Classification: Integrated Delivery System

Service Area: Eastern Massachusetts

Partners HealthCare is an integrated health system founded by Brigham and Women's Hospital and Massachusetts General Hospital. In addition to two academic medical centers, the Partners Pioneer ACO includes community and specialty hospitals, a physician network, home health and long-term care services, and other health-related entities. Partners' primary service area includes greater Boston and eastern Massachusetts, which has a population of approximately 4.9 million. Partners' mission is dedicated to patient care, research, teaching, and service to the community, locally and globally. Partners is a leading biomedical research organization and a principal teaching affiliate of Harvard Medical School. Partners HealthCare is a non-profit organization.

Partners has a history of partnering with CMS to improve care and reduce costs. In 2006, Massachusetts General Hospital (MGH) launched the Care Management Program, one of six demonstration projects nationwide. During the three-year demonstration, MGH developed new strategies to improve the delivery of health care to its most vulnerable high risk patients, those with multiple health conditions and chronic disease. In 2009 CMS renewed the demonstration; Partners expanded the initiative to Brigham and Women's and North Shore Medical Center.

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Physician Health Partners

Classification: Network of Independent Practice Associations

Service Area: Denver, CO Metropolitan Area

Physician Health Partners, a medical management company formed in 2006, and its strategic partner independent practice associations (IPAs), KEY, Primary Physician Partners and South Metro Primary Care, collaborate to improve patient care while lowering the costs associated. Physician Health Partner's primary care physician model focuses on creating medical homes, providing care resources and managing the care of their patients throughout various healthcare settings. Based in Denver, this collaborative consists of more than 260 primary care physicians who provide care for approximately 450,000 people in the seven-county metro area.

As one of the selected Pioneer Accountable Care Organizations (ACO), Physician Health Partners will work with hospital systems, like-minded specialists, and community resources to improve care and the Medicare experience for more than 28,000 patients.

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Presbyterian Healthcare Services – Central New Mexico Pioneer Accountable Care Organization

Classification: Integrated Delivery System
Service Area: Central New Mexico

Presbyterian Healthcare Services (PHS) is a not-for-profit integrated delivery system located in New Mexico. PHS consists of eight hospitals, the Presbyterian Medical Group, a multi-specialty physician group with over 30 clinics and the Presbyterian Health Plan, which insures over 400,000 New Mexicans. For more than 100 years, Presbyterian has been committed to a single purpose -- improving the health of the patients, members, and communities we serve.

The Presbyterian Healthcare Services – Central New Mexico (PHS-CNM) Pioneer Accountable Care Organization is based within the Presbyterian Central Delivery System (PCDS), which is located in central New Mexico. PCDS consists of three acute-care hospitals with over 600 licensed beds and the Presbyterian Medical Group. PCDS is affiliated with TriCore Reference Laboratories and Albuquerque Ambulance, based in Albuquerque, New Mexico and the University of Texas MD Anderson Cancer Center. PCDS has been awarded the Beacon Award for Critical Care Excellence from the American Association of Critical Care Nurses, the Energy Star Award from the U.S. Environmental Protection Agency, the Consumer Choice Award from the National Research Corporation and the 2011 Leapfrog Top Hospital Award. This is the first Medicare pilot in which PCDS will participate.

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PrimeCare Medical Network

Classification: Medical Groups and Independent Practice Associations (IPAs)

Service Area: Southern California (San Bernadino and Riverside Counties)

The PrimeCare Medical Network, Inc. (“PMNI”) ACO is a network of twelve independent practice associations (IPAs) and two medical groups with over 200 primary care providers and 1,000 specialists caring for the communities of San Bernardino and Riverside Counties in Southern California, also known as the Inland Empire. Organized as independent physicians with private practice offices located throughout the Inland Empire, the PMNI physicians have offered convenient, quality health care for over 17 years. Additionally, PMNI has developed patient-centered programs and systems that have enabled the organization to successfully build a sustainable, innovative health care delivery platform focused on the patient-physician relationship. Participation in the Pioneer ACO is consistent with the PMNI vision and strategy in coordinating care across the spectrum of providers. PMNI has participated in multiple health plan pay-for-performance quality programs designed to improve patient care and experience.

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Renaissance Medical Management Company

Classification: Independent Practice Association (IPA)

Service Area: Southeastern Pennsylvania

Founded in 1998, Renaissance Medical Management Company, Inc. (RMMC) is an Independent Practice Association (IPA) owned and managed by primary care physicians in Southeastern Pennsylvania. Remaining true to the objectives of improving quality and outcomes, while decreasing cost, the organization has supported independent primary care practices to achieve PCMH designation, EMR implementation, policy and procedure development, and other activities tailored to achieve population management through best practices.

RMCC's model to improve the delivery of care has been designed, developed, and implemented with the real-world perspectives of doctors. RMMC's programs and initiatives have delivered quality and cost reductions that have been confirmed by independent third parties. RMCC's performance has generated medical cost savings when compared to a control group and adjusted for the traditional actuarial adjustments (age, sex, risk factors, unit cost adjustments, geography adjustment).

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Seton Health Alliance

Classification: Partnership of hospital system and medical practices

Service Area: Central Texas (11 county region)

Seton Health Alliance is an open network of health care providers currently comprised of Seton Healthcare Family and Austin Regional Clinic (ARC). This network is open to community physicians and partners, and the entity has come together to better coordinate the health care of Medicare patients. Seton serves an 11-county region in Central Texas that includes 13 hospitals in seven cities including Austin, the State's Capitol, the surrounding towns of Round Rock and Kyle, as well as the rural communities of Luling, Burnet, Smithville and Harker Heights. It includes 21 primary and specialty care outpatient clinics in six cities, including Austin, Round Rock, Cedar Park, Hutto, Pflugerville, and Kyle. (This includes 18 Austin Regional Clinic locations and Seton's Community Health Centers—Topfer, Kozmetsky and McCarthy.)

Seton Health Alliance provides a patient-centered approach to patients. Medicare beneficiaries aligned with Seton will continue to have a choice of physicians, locations and appointment times, including four After Hours Clinics, where patients can be seen in a clinic setting staffed by physicians after regular hours. Services available 24 hours a day will include phone nurses, online education resources, online appointment requests and online bill-pay.

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Sharp Healthcare System

Classification: Integrated Health System

Service Area: San Diego County

Sharp HealthCare Accountable Care Organization (ACO) is an integrated health system that will serve nearly 33,000 Medicare beneficiaries in San Diego County. Sharp HealthCare ACO includes: most physicians who are part of Sharp Community Medical Group, an independent physician association, including Graybill Medical Group; all physicians with Sharp Rees-Stealy Medical Group, a multispecialty medical group practice; and all Sharp HealthCare hospitals including Sharp Chula Vista Medical Center, Sharp Coronado Hospital, Sharp Grossmont Hospital, Sharp Mary Birch Hospital for Women & Newborns, Sharp Mesa Vista Hospital and Sharp Memorial Hospital.

A 2007 Malcolm Baldrige National Quality Award recipient, Sharp is on a journey to transform the health care experience. Through The Sharp Experience, Sharp is dedicated to creating personal experiences for patients built on dignity, compassion and respect, and by using clinical excellence and advanced technology to deliver the highest quality patient care.

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Steward Health Care System

Classification: Integrated Delivery System

Service Area: Eastern Massachusetts

Steward Health Care System is the largest, integrated community care organization and community hospital network in New England. Headquartered in Boston, Massachusetts, Steward has more than 16,000 employees serving more than one million patients annually in over 85 communities. Steward's hospitals include Saint Anne's in Fall River, Holy Family Hospital in Methuen, St. Elizabeth's Medical Center in Brighton, Norwood Hospital, Carney Hospital in Dorchester, Good Samaritan Medical Center in Brockton, Nashoba Valley Medical Center in Ayer, Merrimack Valley Hospital in Haverhill, Morton Hospital and Medical Center in Taunton and Quincy Medical Center. Additional Steward entities include Steward Medical Group, Steward Health Care Network, Steward Hospice and Home Care, Laboure College, and Por Cristo.

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TriHealth, Inc.

Classification: Integrated Delivery System

Service Area: Northwest Central Iowa

Trinity Health Systems/TriHealth, Inc. is an integrated healthcare system located in Fort Dodge, Iowa. Trinity delivers coordinated health services in an eight-county service area in predominately rural, northwest central Iowa. Organizations affiliated with Trinity: include a sole community acute care hospital, a community mental health center, several rural health clinics, a medical group including primary care and specialty providers, and a home health agency. Specifically, this ACO is anchored by Trinity Regional Medical Center, Berryhill Center for Mental Health, Trimark Physicians Group, and Iowa Health Home Care. Susan Thompson is the President/CEO of Trinity Health Systems.

Trinity Health Systems is a senior affiliate of Iowa Health System, one of the nation's most integrated health systems. Iowa Health System is a community-organization of hospitals and physicians who share a common vision for the delivery of high quality, affordable and accessible healthcare services. As the fifth largest nondenominational health system in America, Iowa Health System has relationships with 26 hospitals and more than 195 physician clinic locations in Iowa and Illinois and employs more than 22,000 employees.

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University of Michigan Health System

Classification: Integrated Delivery System

Service Area: Southeastern Michigan

The University of Michigan Health System will participate in the Pioneer ACO and serve the southeastern Michigan area. U-M will partner with IHA Health Services Corporation, an Ann Arbor-based healthcare provider group with 175 physicians in 32 practices. The U-M Faculty Group Practice, part of the U-M Medical School, includes all of the nearly 1,600 U-M faculty physicians who care for patients at the three U-M hospitals and 40 U-M health centers.

U-M hopes the Pioneer ACO Model will continue to build on its work in the Medicare Physician Group Practice Demonstration. In that five-year project, U-M's Faculty Group Practice saved Medicare more than \$22 million by efficiently caring for Medicare patients. Of the ten groups that participated, U-M was one of only two that earned shared savings during all five years of the demonstration. And in the last year of the project, U-M scored a 98 percent grade on quality measures. U-M also currently is participating in a similar project known as the PGP Transition Demonstration.

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FACT SHEET

FOR IMMEDIATE RELEASE
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Contact: CMS Media Relations Group
(202) 690-6145

Pioneer Accountable Care Organization Model: General Fact Sheet

The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as Accountable Care Organizations (ACOs) or in similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model will test the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients, and reducing Medicare costs.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are one way CMS is working to ensure better health care, better health, and lower growth in expenditures through continuous improvement.

The Medicare Shared Savings Program provides incentives for ACOs that meet standards for quality performance and reduce cost while putting patients first. Established by the Affordable Care Act, CMS published final rules for the Shared Savings Program on November 2, 2011. More information is available at www.cms.gov/sharedsavingsprogram.

Working in concert with the Shared Savings Program, the Innovation Center is testing an alternative ACO model, the Pioneer ACO Model. The Innovation Center is also testing the Advance Payment ACO Model, which will provide additional support to physician-owned and rural providers participating in the Shared Savings Program who would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems.

More information on all of these initiatives is available on the Innovation Center website at www.innovations.cms.gov.

The Pioneer ACO Model and Selected Organizations

The Pioneer ACO Model was designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements. The selected organizations were chosen for their significant experience offering this type of quality care to their patients, along with other criteria listed in the Request for Applications (RFA) document available at www.innovations.cms.gov. These organizations were selected through an open and competitive process from a large applicant pool that included many qualified organizations.

The 32 organizations participating in the Pioneer ACO Model:

Organization	Service Area
1. Allina Hospitals & Clinics	Minnesota and Western Wisconsin
2. Atrius Health Services	Eastern and Central Massachusetts
3. Banner Health Network	Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)
4. Bellin-Thedacare Healthcare Partners	Northeast Wisconsin
5. Beth Israel Deaconess Physician Organization	Eastern Massachusetts
6. Bronx Accountable Healthcare Network (BAHN)	New York City (the Bronx) and lower Westchester County, NY
7. Brown & Toland Physicians	San Francisco Bay Area, CA
8. Dartmouth-Hitchcock ACO	New Hampshire and Eastern Vermont
9. Eastern Maine Healthcare System	Central, Eastern, and Northern Maine

10. Fairview Health Systems	Minneapolis, MN Metropolitan Area
11. Franciscan Health System	Indianapolis and Central Indiana
12. Genesys PHO	Southeastern Michigan
13. Healthcare Partners Medical Group	Los Angeles and Orange Counties, CA
14. Healthcare Partners of Nevada	Clark and Nye Counties, NV
15. Heritage California ACO	Southern, Central, and Costal California
16. JSA Medical Group, a division of HealthCare Partners	Orlando, Tampa Bay, and surrounding South Florida
17. Michigan Pioneer ACO	Southeastern Michigan
18. Monarch Healthcare	Orange County, CA
19. Mount Auburn Cambridge Independent Practice Association (MACIPA)	Eastern Massachusetts
20. North Texas Specialty Physicians	Tarrant, Johnson and Parker counties in North Texas
21. OSF Healthcare System	Central Illinois
22. Park Nicollet Health Services	Minneapolis, MN Metropolitan Area
23. Partners Healthcare	Eastern Massachusetts
24. Physician Health Partners	Denver, CO Metropolitan Area

25. Presbyterian Healthcare Services – Central New Mexico Pioneer Accountable Care Organization	Central New Mexico
26. Primecare Medical Network	Southern California (San Bernardino and Riverside Counties)
27. Renaissance Medical Management Company	Southeastern Pennsylvania
28. Seton Health Alliance	Central Texas (11 county area including Austin)
29. Sharp Healthcare System	San Diego County
30. Steward Health Care System	Eastern Massachusetts
31. TriHealth, Inc.	Northwest Central Iowa
32. University of Michigan	Southeastern Michigan

The Innovation Center

The Innovation Center was created by the Affordable Care Act to test new models of health care delivery and payment. The Center also offers technical support to providers to improve the coordination of care and share lessons learned and best practices throughout the health care system. It is committed to refining the Medicare, Medicaid and CHIP programs to deliver better care for individuals, better health for populations, and lower growth in expenditures.

Payment Arrangement and Beneficiary Alignment

The first performance period begins in January 1st, 2012. In the first two performance years, the Pioneer Model tests a shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program. These shared savings would be determined through comparisons against an ACO’s benchmark, which is based on previous CMS expenditures for the group of patients aligned to the Pioneer ACO

In year three of the program, those Pioneer ACOs that have shown savings over the first two years will be eligible to move to a population-based payment model. Population-based payment

is a per-beneficiary per month payment amount intended to replace some or all of the ACO's fee-for-service (FFS) payments with a prospective monthly payment.

Additionally, during the application process, organizations were invited to propose alternative payment arrangements. CMS established two alternatives to the core payment arrangement discussed above based on this input. Both of these alternatives follow a shared savings model in years one and two, and provide an option for a partial population based payment that removes limits on rewards and risks in year three. These arrangements will allow Pioneer ACOs more flexibility in the speed at which they assume financial risk.

Under the Pioneer ACO Model, CMS will prospectively align beneficiaries to ACOs, allowing care providers to know at the beginning of a performance period for which patients' cost and quality they will be held accountable.

Beneficiary Protections and Quality Measures

Providing the beneficiary with a better care experience is one of the central focuses of the Pioneer ACO Model. Under the Pioneer ACO Model, beneficiaries will maintain the full benefits available under traditional Medicare (fee-for-service), as well as the right to receive services from any healthcare provider accepting Medicare patients.

To ensure beneficiaries receive high quality care and enjoy a positive experience, CMS has established robust quality measures that will be used to monitor the quality of care provided and beneficiary satisfaction. These measures mirror those in the Shared Savings Program. For more information, visit www.cms.gov/sharedsavingsprogram and view the fact sheet entitled "Improving Quality of Care for Medicare Patients: Accountable Care Organizations."

More information about beneficiary protections and quality measures is available in the fact sheet entitled "The Pioneer ACO Model: A Better Care Experience Through a New Model of Care."

Eligibility Criteria/Program Requirements

To be eligible to participate in the Pioneer ACO Model, organizations are required to be providers or suppliers of services structured as:

- 1) ACO professionals in group practice arrangements;
- 2) Networks of individual practices of ACO professionals;
- 3) Partnerships or joint venture arrangements between hospitals and ACO professionals;
- 4) Hospitals employing ACO professionals; or
- 5) Federally Qualified Health Centers (FQHC).

Health Information Technology

By the end of 2012, Pioneer ACOs must attest and CMS will confirm that at least 50% of the ACO's primary care providers have met requirements for meaningful use of certified electronic health records (EHR) for receipt of payments through the Medicare and Medicaid EHR Incentive Programs.

Minimum Number of Aligned Beneficiaries

Beneficiaries are aligned to ACOs through the healthcare providers that choose to participate. CMS will review where a beneficiary has been receiving the plurality of his/her primary care services, and use that information to establish which beneficiaries are aligned to a participating provider. If a primary care provider chooses to participate in an ACO, the beneficiaries aligned to him or her through this process would be aligned to the ACO. If a beneficiary receives less than 10 percent of their care from a primary care provider, CMS will review where a beneficiary has been receiving the majority of his/her specialty services to determine alignment.

Participants generally must have a minimum of 15,000 aligned beneficiaries unless located in a rural area, in which case are to have a minimum of 5,000 beneficiaries. In order to be aligned, beneficiaries must be enrolled in original, fee for service Part A and B Medicare. They cannot be participating in Medicare Advantage plans.

Participation of Other Payers

The Innovation Center believes that Pioneer ACOs will be more effective in producing improvements in three part aim of better care for individuals, better health for populations, and slower growth in expenditures if they fully commit to a business model based on financial and performance accountability. The Innovation Center therefore requires Pioneer ACOs to enter similar contracts with other payers (such as insurers, employer health plans, and Medicaid) such that more than 50 percent of the ACO's revenues will be derived from such arrangements by the end of the second Performance Period.

Selection Process

CMS conducted a lengthy, open and competitive application process to select the final participants in the Pioneer ACO Model. CMS released a Request for Applications (RFA) in May 2011 that detailed the selection criteria. Applicants were required to submit both a Letter of Intent and Application. Applications were reviewed by a panel of experts from the Department of Health and Human Services as well as from external organizations, with expertise in the areas of provider payment policy, care improvement and coordination, primary care, and care of vulnerable populations. These panels assessed the applications based on the criteria detailed in the RFA. Applicants with the highest scores were invited to participate in interviews with Innovation Center leadership at the CMS facility in Baltimore. Based on these interviews, CMS

chose a pool of finalists. The Pioneer ACOs announced in December 2011 were those finalists choosing to sign a final agreement with CMS.

Pioneer ACO Model and the Shared Savings Program

The Pioneer ACO Model is distinct from the Shared Savings Program. The Shared Savings Program fulfills a statutory obligation set forth by the Affordable Care Act to establish a permanent program that develops a pathway forward for groups of health care providers to become ACO's, while the Pioneer ACO Model is an initiative designed to test the effectiveness of a particular model of payment. Final rules for the Shared Savings Program were published in November 2011. More information is available at www.cms.gov/sharedsavingsprogram.

The Pioneer ACO Model differs from the Medicare Shared Savings Program in the following ways, among others:

- The first two years of the Pioneer ACO Model are a shared savings payment arrangement with higher levels of savings and risk than in the Shared Savings Program.
- Starting in year three of the initiative, those organizations that have earned savings over the first two years will be eligible to move to a population-based payment arrangement and full risk arrangements that can continue through optional years four and five.
- Pioneer ACOs are required to develop similar outcomes-based payment arrangements with other payers by the end of the second year, and fully commit their business and care models to offering seamless, high quality care.

Additional Information

Additional information about the Pioneer ACO Model is available on the Pioneer ACO Model website - <http://www.innovations.cms.gov/initiatives/aco/pioneer>

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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FACT SHEET

FOR IMMEDIATE RELEASE
December 19, 2011

Contact: CMS Media Relations Group
(202) 690-6145

The Pioneer ACO Model: A Better Care Experience Through a New Model of Care

Overview

The Pioneer ACO Model is a CMS Innovation Center initiative designed to test the effectiveness of particular payment arrangements in providing beneficiaries with a better care experience through Accountable Care Organization (ACO), while also reducing Medicare costs.

To help ensure beneficiaries receive high quality care, CMS has instituted robust quality measures for participating ACOs that will help track the health of beneficiaries as well as the quality of their experience. In addition, beneficiaries aligned to the Pioneer ACO Model will maintain the full rights and benefits of original, fee-for-service Medicare, including the right to see any provider accepting Medicare at any time.

This fact sheet provides a general description of the benefits offered to Medicare beneficiaries participating in the Pioneer ACO Model.

A Better Care Experience Through a New Model of Care

Any patient who has multiple doctors probably understands the frustration of fragmented and disconnected care: lost or unavailable medical charts, doctors who don't coordinate their decisions with one another, duplicated medical procedures, or having to share the same information over and over with different doctors.

Accountable Care Organizations are designed to lift this burden from patients, while improving the partnership between patients and doctors in making health care decisions. Medicare beneficiaries will have better control over their health care, and their doctors can provide better care because they will have better information about their patients' medical history and can communicate more readily with a patient's other doctors.

Beneficiary Participation

Under the Pioneer ACO Model, beneficiaries do not enroll in an ACO. Primary care providers and other healthcare providers make the decision to participate in ACOs, meaning a beneficiary will not need to take proactive action to receive the benefits offered through an ACO. ACOs are required to notify beneficiaries of their participation, ensuring the beneficiary is aware of the new arrangement, and his or her rights described in this document. In addition, beneficiaries may affirmatively attest that their primary provider is in a Pioneer ACO, and can then be aligned with the ACO and benefit from the enhanced care coordination that it offers.

Beneficiary Rights and Protections

A beneficiary aligned to an ACO maintains complete freedom to visit any healthcare provider accepting Medicare, just as all Medicare beneficiaries participating in original, fee-for-service Medicare do. These beneficiaries do not need a referral to see a specialist outside the ACO. Unlike a managed care arrangement, like an HMO or a Medicare Advantage plan, a beneficiary aligned to an ACO is free to see any healthcare provider accepting Medicare at any time. In addition, beneficiaries maintain all the benefits to which they are entitled in original, fee-for-service Medicare.

Beneficiaries will have direct channels of communication to CMS to ask questions and relay concerns. Through the initial notice of participation, beneficiaries will be informed that they can call 1-800 MEDICARE at any time to ask questions about the program, alert CMS of any concerns they may have about the ACO. Beneficiaries will also be surveyed each year to assess their experience with the new program.

Program Monitoring

The Pioneer ACO Model is designed to encourage the delivery of more seamless care that can reduce Medicare expenditures through better, more coordinated care. When successful, the elimination of duplicative, unnecessary processes should improve quality of care and generate savings to the Medicare program. ACO participants will be responsible for sharing in losses if they can't help reduce costs while maintaining quality standards.

CMS takes seriously its responsibility to prevent any attempts to reduce the delivery of necessary care. Under the Pioneer ACO Model, CMS will routinely analyze data surrounding utilization of services, and will take steps to further investigate any suspect trends, including steps such as beneficiary surveys, audits, and other means. As part of this work, CMS will also compare the experience and health of beneficiaries who are aligned to an ACO in the Pioneer ACO Model against comparable beneficiaries not aligned to an ACO.

Governance Structure – Giving Beneficiaries a Seat at the Table

The Innovation Center believes it is important that patients and their advocates be meaningful partners in improving care delivery. To ensure patient concerns are considered in all ACO decisions, Pioneer ACOs will be required to include both a patient representative *and* a consumer advocate on their governing body. The Model’s rules allow both roles to be filled by a single person, but the vast majority of Pioneer ACOs have one of each.

Quality Measures

Under the Pioneer ACO Model, ACOs will be held financially accountable for both the care delivered to and the health of their aligned populations. In order to effectively track this care and health, CMS has established quality measures by which ACOs will be judged. These quality measures are identical to those in place for the Medicare Shared Savings Program, as established by the final rule released in November 2011. More information about the Shared Savings Program is available at www.cms.gov/sharedsavingsprogram.

These final quality measures are a reflection of extensive feedback CMS received during the comment period on the Shared Savings Program proposed rule. This feedback came from sources ranging from consumer advocates to healthcare providers.

CMS published a fact sheet on these new measures in October 2011: “Improving Quality of Care for Medicare Patients: Accountable Care Organizations.” This fact sheet is available on the website of the Medicare Shared Savings Program at www.cms.gov/sharedsavingsprogram.

Data Use

To help primary care providers and other providers participating in ACOs offer beneficiaries the right care at the right time in the right setting, CMS will share with participating ACOs some types of Medicare data about aligned beneficiaries. This data will include a history of medical claims that can provide ACOs with a more complete view of the beneficiary’s complete medical needs.

At any time, beneficiaries may opt out of having their identifiable data shared with the Pioneer ACO. Beneficiaries will receive written notification from Pioneer ACOs regarding this right, along with information about how to perform this opt-out. In addition, beneficiaries will be able to opt out of sharing this data through calling 1-800 MEDICARE or completing a form provided to beneficiaries with their notification. Beneficiaries will have 30 days to respond before this information will be shared with ACOs, though beneficiaries maintain the ability to opt out at any time.

The automatic sharing detailed above does not apply to treatment a beneficiary received for substance abuse. This sharing may only take place if the beneficiary provides explicit written permission to do so.

Each of the processes detailed here may only occur under appropriate data use agreements, and in compliance with all relevant federal laws.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Dec 2014 12:50:09 -0500
To: Bucklen, Kim L. (CMS/CQISCO);CBC Staff;Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Manweiler, Kelsey (Shelby);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];Paul Winfree (Sessions/Budget);Sewell, Terri (Hillary Beard);Shelby, Richard (Jay Dunn);Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Al-Kourainy, Amir (Bill Nelson);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Katie Wise);Clawson, Curt (Jeff Post);Crenshaw, Ander;Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gittess, David (Bill Nelson);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (LaTasha Lee);Hastings, Alcee (Mike Sykes);Joe Garcia (Anna Gonzalez);John Mica (Casey.Brinck@mail.house.gov);Jolly, David (LJ Govoni);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Laura Cooper);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Eduardo Sacasa);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Dolan, Coby);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (Bobby McMillin);Collins, Doug (Jennifer Lackey);Collins, Doug (Vernon Robinson);David Scott (lauren.lattany@mail.house.gov);Graves, Tom (Bo Butler);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Marshall Thomas);'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Coulter, Margaret (HELP Committee));Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Gribble, Kristi);Ellmers, Renee (Mitchell Vakerics);Farrar, Elizabeth

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Announces State Innovation Models (SIM) Award Round 2 Recipients

Attachments: FINAL State Innovation Models Round Two Fact Sheet FORMATTED.PDF

U.S. House and Senate Notification
Tuesday, December 16, 2014

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: HHS Announces State Innovation Models (SIM) Award Round 2 Recipients

Today, the Department of Health and Human Services (HHS) announced the recipients of the second round of the State Innovation Models (SIM) initiative, which will provide nearly \$665 million to support state-led, multi-payer health care payment and service delivery models. Today's announcement includes \$622 million for Model Test awards for states to implement their State Health Care Innovation Plans and nearly \$43 million for Model Design awards for states to design or further refine their State Health Care Innovation Plans. A total of 28 states, 3 territories and the District of Columbia will receive funding through round two of SIM.

Model Test awards will support Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee and Washington in implementing their State Health Care Innovation Plans. The selected states will use funds to test multi-payer payment and service delivery models, such as Accountable Care Organizations and Patient-Centered Medical Homes, on a broad scale within their state. These new awardees join 6 states currently in the testing phase of the State Innovation Models initiative.

Model Design awards will support twenty-one awardees, including 17 states, 3 territories, and the District of Columbia (American Samoa, Arizona, California, Hawaii, Kentucky, Illinois, Maryland, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Northern Mariana Islands, Oklahoma, Pennsylvania, Puerto Rico, Utah, Virginia, West Virginia, Wisconsin). These states will further develop proposals for comprehensive health care transformation.

A fact sheet which includes project profiles for the Model Test awards is attached. For more information about the SIM Awards visit: <http://innovation.cms.gov/initiatives/State-Innovations/>

Please contact the CMS Office of Legislation if you have any questions. Thank you.



FACT SHEET

FOR IMMEDIATE RELEASE
December 16, 2014

Contact: CMS Media Relations
(202) 690-6145 | press@cms.hhs.gov

State Innovation Models Initiative Round Two

The Centers for Medicare and Medicaid Services (CMS) announced the recipients of 11 Model Test and 21 Model Design awards under the second round of the State Innovation Models initiative on December 16, 2014.

In round two, the State Innovation Models initiative is providing more than \$665 million over the next four years to support state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states. This includes both model “design” awardees (states/entities that are designing plans and strategies for statewide innovation) and model “test” awardees (states that are taking the next step from “designing” to “testing” and implementing comprehensive statewide health transformation plans). States will engage a broad group of stakeholders including health care providers and systems, long-term service and support providers, commercial payers, state hospital and medical associations, tribal communities and consumer advocacy organizations. Transformation efforts supported by this initiative must improve health, improve care, and lower costs for Medicare, Medicaid, and CHIP beneficiaries. Accordingly, all awardees are committed to developing and implementing innovative delivery and payment models that yield better health, better care and reduced costs.

Over \$622 million in Model Test awards will support 11 states that are ready to implement their State Health Care Innovation Plans. A State Health Care Innovation Plan is a fully developed proposal capable of creating statewide health transformation for the preponderance of care within a state. In addition, a State Health Care Innovation Plan describes a state’s strategy to utilize available regulatory and policy levers to accelerate transformation, such as plans to align quality measures, leverage the adoption and implementation of health information technology and health information exchange, and evaluate innovation efforts. CMS will work with Model Test states for four years.

Nearly \$43 million in Model Design awards will support 21 awardees (including 17 states, three territories and the District of Columbia) in designing or further refining State Health Care

Innovation Plans. The Model Design award recipients will engage a diverse group of stakeholders, including public and commercial payers, providers and consumers, to develop a State Health Care Innovation Plan. States receiving Model Design awards under the State Innovation Models initiative will have twelve months to submit their State Health Care Innovation Plans to CMS.

With these new awardees, now over half of states representing 61 percent of the U.S. population (38 total State Innovation Models initiative awardees, including 34 states, three territories and the District of Columbia) will be working in efforts to support comprehensive state-based innovation in health system transformation.

Note: Descriptions and project data are estimates provided by the state and are based on budget submissions required by the State Innovation Models initiative application process.

States Receiving Model Test Awards

The following states will receive Model Test awards. Continued funding will be subject to state performance, compliance with the terms and conditions of the award, and demonstrated progress towards the goals and objectives of the State Innovation Model initiative.

Colorado

Over the next 48 months, the State of Colorado will receive up to \$65 million to implement and test its State Health Care Innovation Plan. Colorado's plan, entitled "The Colorado Framework," creates a system of clinic-based and public health supports to spur innovation. The state will improve the health of Coloradans by: (1) providing access to integrated primary care and behavioral health services in coordinated community systems; (2) applying value-based payment structures; (3) expanding information technology efforts, including telehealth; and (4) finalizing a statewide plan to improve population health. Funding will assist Colorado in integrating physical and behavioral health care in more than 400 primary care practices and community mental health centers comprised of approximately 1,600 primary care providers. In addition, the state will work to establish a partnership between their public health, behavioral health and primary care sectors.

Connecticut

Over the next 48 months, the State of Connecticut will receive up to \$45 million to implement and test its State Health Care Innovation Plan. Connecticut's plan utilizes several statewide and locally targeted interventions to: (1) improve population health; (2) strengthen primary care; (3) promote value-based payment and insurance design; and (4) obtain multi-payer alignment on quality, healthy equity, and care experience measures. Specifically, the state will implement a Medicaid Quality Improvement Shared Savings Program (MQISSP). Primary care providers participating in the MQISSP will benefit from programs designed to enhance primary care capacity in the state, including learning collaboratives to foster continuous learning. Connecticut will implement Health Enhancement Communities and Prevention Service Centers focused on improving population health. The state will expand inter-professional training, enhance primary care capacity through additional residency programs, and increase community health worker training to ensure its health care workforce can support the transformation efforts. Lastly, the state will develop a core quality measurement set for primary care providers and select

specialists that will capture a cross-payer measure of care experience tied to value-based payment in a common provider scorecard.

Delaware

Over the next 48 months, the State of Delaware will receive up to \$35 million to implement and test its State Health Care Innovation Plan. Delaware will: (1) support ten community-based population health programs (Health Communities); (2) develop an IT infrastructure to support a cross-payer scorecard of core measures available to providers with related tools for patient engagement and price and quality transparency; and (3) engage payers in the development of a pay-for-value model and a total-cost-of-care model for providers (including independent primary care providers), with the goal of attributing all Delawareans to a primary care provider (PCP) during the performance period. In addition, the state will offer technical assistance to providers focusing on models of integrated, team-based care and transition to value-based payment models. Delaware will implement workforce development strategies to build competencies and address the current workforce shortage and will also develop educational programs to address the needs of model participants.

Idaho

Over the next 48 months, the State of Idaho will receive approximately \$39.6 million to implement and test its State Health Care Innovation Plan. Idaho will achieve statewide health care system transformation that will deliver integrated, efficient and effective primary care services through patient-centered medical homes (PCMHs). Specifically, Idaho will build 180 Nationally Recognized PCMH practices, including 75 Virtual PCMHs, by the end of the Model Test. Practices will be selected from each of the seven Health Districts in Idaho during the test period. The state will also support providers through expanded connectivity via electronic health information exchange, and by aligning the support of public and private payers to accelerate practice transformation.

Iowa

Over the next 48 months, the State of Iowa will receive up to \$43.1 million to implement and test its State Health Care Innovation Plan. Iowa's plan for health system transformation builds upon the Accountable Care Organization (ACO) model that currently covers the state's expanded Medicaid population, called the Iowa Health and Wellness Plan. This population-based model also will align with quality measures and payment methodology (shared savings and calculation of total-cost-of-care) utilized by the Wellmark commercial ACOs. In addition, the state will work with the same data analytics contractor as Wellmark so that provider organizations have consistent and usable data to transform their practice from volume-based reimbursement to value-based reimbursement. By the end of the performance period, the Medicaid ACOs will be accountable for the long term care and behavioral health services of their attributed patients. Iowa will use SIM funding to integrate community-based resources into the ACOs by providing technical assistance through various partners. The state also will leverage and spread existing community transformation initiatives focused on the social determinants of health.

Michigan

Over the next 48 months, the State of Michigan will receive approximately \$69.9 million to implement and test its State Health Care Innovation Plan. Michigan will implement its *Blueprint*

for Health Innovation with the creation of Accountable Systems of Care (ASCs). ASCs will be networks of providers utilizing patient-centered medical homes supported by payment models that align incentives. The ASCs are further supported by Community Health Innovation Regions (CHIRs), which are cross-sector partnerships that address population health and connect patients with relevant community services. The state will test whether ASCs working with CHIRs can achieve better health outcomes at lower cost for three targeted populations of patients: those with adverse birth outcomes, frequent emergency department users, and those with multiple chronic conditions. Through SIM funding and resources, Michigan will deliver technical assistance, workforce training, quality improvement skills, and data analytics to providers throughout the state.

New York

Over the next 48 months, the State of New York will receive approximately \$99.9 million to implement and test its State Health Care Innovation Plan. New York will adopt a tiered Advanced Primary Care (APC) model for primary care. This model will include behavioral and population health, and be complemented by a strong workforce and engaged consumers, with supportive payment and common metrics. The state will: 1) institute a statewide program of regionally-based primary care practice transformation to help practices across New York adopt and use the APC model; 2) expand the use of value-based payments so that 80% of New Yorkers are receiving value-based care by 2020; 3) support performance improvement and capacity expansion in primary care by expanding New York's primary care workforce through innovations in professional education and training; 4) integrate APC with population health through Public Health Consultants funded to work with regional Population Health Improvement Program contractors; 5) develop a common scorecard, shared quality metrics and enhanced analytics to assure that delivery system and payment models support three-part aim objectives; and 6) provide state-funded health information technology, including greatly enhanced capacities to exchange clinical data and an all-payer database.

Ohio

Over the next 48 months, the State of Ohio will receive up to \$75 million to implement and test its State Health Care Innovation Plan. Ohio will transform the state's health care system by rapidly scaling the use of patient-centered medical homes (PCMHs) and episode-based models and by developing cross-cutting infrastructure to support implementation and sustain operations. By the end of the Model Test, Ohio plans to launch 50 episodes of care and implement PCMHs statewide. Reports for the first six episodes of care will be delivered to providers in November 2014. PCMHs will expand geographically, reaching statewide coverage by 2018. In addition, the state is focused on incorporating population health measures into regulatory and payment systems in order to use those measures to align population health priorities across clinical services, public health programs, and community-based initiatives.

Rhode Island

Over the next 48 months, Rhode Island will receive up to \$20 million to implement and test its State Health Care Innovation Plan. Rhode Island will implement a population health plan based on the results of community health assessments, including the integration of primary care and behavioral health. In addition, the state will expand the use of health homes by providers in the state, thus serving a substantial majority of the state's population. In order to facilitate and

support much of this transformation activity, the state will establish a Transformation Network to provide technical assistance and analytical capabilities to payers and providers participating in the value-based models. The state will augment its Health Information Technology (HIT) infrastructure to include an all-payer claims database, statewide health care quality measurement, patient engagement tools, and state data management and analytics.

Tennessee

Over the next 48 months, the State of Tennessee will receive up to \$65 million to implement and test its State Health Care Innovation Plan. Tennessee will execute multi-payer payment and delivery reform strategies. The state will accelerate transformation in primary care by developing pediatric and adult patient-centered medical homes (PCMHs) and health homes that will integrate value-based behavioral and primary care services for people with Severe and Persistent Mental Illness. In addition, Tennessee plans to implement 75 multi-payer episodes of care to reward high-quality and efficient acute health care over the test period. Tennessee will also implement quality and acuity-based payment and delivery system reform for long-term services and support (LTSS), targeting nursing facility services and home and community based services for seniors and adults with physical, intellectual and developmental disabilities. Finally, the state is planning to develop a statewide plan for improving population health in order to address disparities and state-specific population health needs.

Washington

Over the next 48 months, the State of Washington will receive approximately \$64.9 million to implement and test its State Health Care Innovation Plan. The Healthier Washington project will move health care purchasing from volume to value, improve health of state residents, and deliver coordinated whole-person care. Washington will make targeted investments in the following areas: (1) community empowerment and accountability, through the implementation of regionally organized Accountable Communities of Health; (2) practice transformation and support through a “support hub”; (3) payment redesign, through shared savings and total-cost-of-care models in collaboration with delivery system and payer partners; (4) analytics, interoperability and measurement; and (5) project management, through a public-private leadership council with a dedicated interagency team and legislative oversight.

States receiving Model Design Awards:

Seventeen States, 3 Territories and the District of Columbia will receive nearly \$43 million in Model Design Awards. Below are the funding amounts:

State	Award Amount
American Samoa	\$750,000
Arizona	\$2,500,000
California	\$3,000,000
District of Columbia	\$999,998
Hawaii	\$1,500,000
Kentucky	\$2,000,000
Illinois	\$3,000,000
Maryland	\$2,500,000

Montana	\$999,999
Nevada	\$2,000,000
New Hampshire	\$2,000,000
New Jersey	\$3,000,000
New Mexico	\$1,999,988
Commonwealth of the Northern Mariana Islands	\$750,000
Oklahoma	\$2,000,000
Pennsylvania	\$3,000,000
Puerto Rico	\$1,944,740
Utah	\$2,000,000
Virginia	\$2,589,792
West Virginia	\$1,939,705
Wisconsin	\$2,494,290

About the Innovation Center

The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care provided to Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) beneficiaries. The Center is committed to refining the Medicare, Medicaid and CHIP programs to deliver better care for beneficiaries while reducing costs. The Innovation Center also offers technical support to states and health care providers improve the coordination of care and share lessons learned and best practices throughout the health care system.

For More Information

More information on the State Innovation Models initiative can be found at: innovation.cms.gov/initiatives/State-Innovations.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 18 Aug 2011 14:32:41 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James)';Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: HHS Awards \$40 Million in Grants to Sign Up Children for Health Coverage

U.S. House and Senate Notification
Thursday, August 18, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: HHS Awards \$40 Million in Grants to Sign Up Children for Health Coverage

Today, the Department of Health & Human Services (HHS) announced the award of \$40 million in grants for efforts to identify and enroll eligible children in Medicaid and the Children's Health Insurance Program (CHIP). Authorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), two-year grants were awarded to a total of 39 State agencies, community health centers, school based organizations and non-profit groups across 23 states. The grants will support successfully proven outreach strategies and focus on several areas, such as using technology to facilitate enrollment and renewal, enlisting schools in outreach and enrollment activities, ensuring eligible teens are able to enroll and remain covered and reaching out to children most likely to experience gaps in coverage. For a list of grantees, please visit: <http://www.insurekidsnow.gov/professionals/reports/chipra/CHIPRA-Cycle-II-Grant-Summaries.pdf>

Today's CHIPRA outreach grant announcement follows the August 12th release of a joint letter from HHS Secretary Kathleen Sebelius and Education Secretary Arne Duncan to the nation's Governors urging them to encourage schools to "undertake children's health coverage outreach and enrollment activities when classes begin this fall." HHS is supporting such efforts by providing a strategy guide to states, schools, community groups, and other stakeholders as part of the "Get Covered, Get in the Game" initiative the agency conducted in 2010.

Please contact the CMS Office of Legislation if you have any questions at 202-690-8220.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 6 May 2011 16:27:23 -0400
To: Bucklen, Kim L. (CMS/CQISCO);'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Gingery, Phil (RobertHorne@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Jack Kingston (Allison.Thigpen@mail.house.gov);Johnson, Hank (scott.goldstein@mail.house.gov)';Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov)';Price, Tom';'Price, Tom (Emily Henehan)';Scott, Austin (Jessica Robertson)';Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Ken.Willis@mail.house.gov)';Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov]';McHenry, Patrick';'McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James)';Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov)';Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: HHS offers support, flexibility for States affected by tornados

**U.S. House and Senate Notification
Friday, May 6, 2011**

To: Congressional Health Staff

**From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: HHS offers support, flexibility for States affected by tornados

In the wake of significant loss of life and property suffered by several States due to recent tornados and other storms, today Health and Human Services Secretary Kathleen Sebelius offered States several

options to speed Medicaid eligibility for those who may desperately need health services but have no means to pay for it.

In a letter to Alabama, Kentucky, Mississippi, and Tennessee, Secretary Sebelius outlines ways States can immediately expand access to health care by providing temporary increases in Medicaid income eligibility limits and removing resource tests. States can also allow residents who may have lost documents in the storm to certify their income and residency, and can delay the process of redetermining whether an individual remains eligible for Medicaid. The Secretary urged States to consult with CMS central and regional offices to determine how best to meet their needs within available legal authority.

In addition, the Secretary provided a commitment that the Department would expedite whatever federal approvals States may need for State plan amendments or waivers, and that such authorities could be retroactive as early as the beginning of the disaster period. Already, HHS is working closely with Alabama on a waiver to help residents in that hard-hit state access the health care they need.

The HHS press release will be available at

<http://www.hhs.gov/news/press/2011pres/05/20110506a.html>. The letter can be viewed at www.hhs.gov/news/press/2011pres/05/letter0506.html. If you have questions about this notification, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 12 Sep 2011 13:41:51 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James)';Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Proposes Broad Patient Rights to Access Clinical Laboratory Test Result Reports

Attachments: 11 9 12 ONC Release FINAL.PDF

Importance: High

Resubmitted with attached ONC Release

U.S. House and Senate Notification

Monday, September 12, 2011

To: Congressional Health Staff

From: Amy Hall

Director, Office of Legislation

Centers for Medicare & Medicaid Services

Re: HHS Proposes Broad Patient Rights to Access Clinical Laboratory Test Result Reports

As part of an ongoing effort across the Department of Health and Human Services (HHS) to empower patients to be informed partners with their health care providers in making health care decisions, HHS today proposed rules that would give patients (and their authorized representatives) direct access to their own laboratory test result reports.

The proposed rules address the interplay between the Clinical Laboratory Improvement Amendments of 1988 (CLIA) rules, state laws governing direct disclosure to patients of their laboratory test results, and the Federal Privacy Rule, which currently defers to CLIA's disclosure provisions and which preempts contrary State laws on privacy and disclosure of personal health information. Under existing CLIA regulations, a laboratory may release patient test results directly to the patient only if (1) the ordering provider expressly authorizes the laboratory to do so at the time the test is ordered, or (2) state law expressly allows for it.

One of the proposed rules would amend the CLIA regulations to allow laboratories to give a patient his/her individual test result reports on request. At the same time, the proposed rule would eliminate the Privacy Rule's exception for an individual's access to laboratory test result reports. The amended Privacy Rule would, in turn, preempt contrary state laws governing a patient's direct access to lab result reports.

This proposed rule is being jointly issued by three agencies within HHS: the Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention, which are responsible for laboratory regulation under CLIA, and the Office for Civil Rights, which is responsible for administering the Privacy Rule that was issued under the Health Insurance Portability and Accountability Act of 1986 (HIPAA). Comments will be accepted for 60 days after publication of the proposed rule in the Federal Register.

For more information, please visit: https://www.cms.gov/apps/media/fact_sheets.asp.

Please contact the CMS Office of Legislation if you have questions at 202-690-8220. Thank you.

FOR IMMEDIATE RELEASE

Monday, September 12, 2011

Contact: HHS Press Office

(202) 690-6343

**Secretary Sebelius spotlights new efforts to empower patients
to increase secure access to their health information**

New Office of Civil Rights Director joins HHS from Department of Justice

HHS Secretary Kathleen Sebelius today proposed new rules that would expand the rights of patients to access their health information through the use of health information technology (IT). Specifically, the new rules would empower patients and allow them to gain access to test results reports directly from labs. They would ensure that labs covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provide such information, upon request, directly to patients or their personal representatives. The announcement came at the kick-off of the first-ever HHS Consumer Health IT Summit, which brought consumers, providers, and the public and private sectors together to discuss how best to empower consumers to be partners in their health and care through health IT.

“When it comes to health care, information is power. When patients have their lab results, they are more likely to ask the right questions, make better decisions and receive better care,” said Secretary Sebelius. “This Summit offers a unique opportunity for the public and private sectors alike to share strategies to improve consumer access to their health information, while safeguarding the privacy and security of their data.”

The Notice of Proposed Rulemaking (NPRM), jointly drafted by the Centers for Medicare & Medicaid Services, the HHS Office for Civil Rights (OCR), and the Centers for Disease Control and Prevention, proposes to amend the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations and HIPAA privacy regulations to strengthen patients’ rights to access their own laboratory test result reports.

Secretary Sebelius also announced the appointment of Leon Rodriguez as the new Director of the Office for Civil Rights. Rodriguez brings his Department of Justice experience to HHS and will be dedicated to ensuring consumers’ health information is kept private and secure.

“Consumers need to know that private and secure access to their health information is a given,” stated OCR Director Rodriguez. “The privacy and security of health data will be a top priority for OCR during my tenure.”

Secretary Sebelius also unveiled today an innovative voluntary Personal Health Record (PHR) Model Privacy Notice, which creates an easy-to-read, standardized template allowing consumers to compare and make informed decisions based on their privacy and security policies and data practices about PHR products. The new template is similar to the Nutrition Facts Labels in that it presents certain complex information in a simple way to improve transparency and consumer understanding about data practices. By making this Model Privacy Notice available, PHR companies can help build greater trust in PHRs.

Today's Summit included more than 25 health care stakeholder organizations, representing consumers, large and small practice providers as well as insurers and health IT industry leaders, that have pledged to empower consumers by making it easier for them to get secure access to their health information to engage more fully in their health.

“As technology improves more aspects of our daily lives, it makes sense to marry cutting-edge technology with our medical and personal health records so that we can improve both the quality and efficiency of the care that people receive,” said National Coordinator for Health Information Technology, Farzad Mostashari, M.D., Sc.M. “We are encouraging everyone to visit our website at www.HealthIT.gov to read our newly released Strategic Plan that sets forth our comprehensive plans for consumer empowerment for the next five years.”

The Summit highlighted vital benefits of electronic health records and health IT, including:

- *Health IT empowers patients.* For example, people at risk for heart attacks may use mobile health applications to manage their weight, diet, and medication adherence.
- *Health IT can facilitate lasting quality improvements,* which can lead to greater efficiency and cost savings in the long-term.
- *Health IT is driving innovation* in all parts of consumers' lives – from new interactive applications to devices like digital pedometers and other devices that capture important health information from everyday experiences.
- *Health IT helps coordinate better care,* and can be a powerful tool if you or a loved one is managing a serious medical condition.
- *Health IT has robust security* and all users, from patients to caregivers to doctors, can easily and safely access and share health information electronically.
- *Health IT may help diagnose health problems sooner,* avoid medical errors and provide safer care which can result in lower costs.

“We are at a critical moment in time when we can either choose to innovate, or lag behind in care,” said Dr. Mostashari. “A commitment by health care stakeholders to support health IT and provide greater consumer access to their health information is the first step toward a healthier future.”

In the coming year, ONC will work with health care stakeholders to further consumer access to information and empower consumers to become active participants in their health. The new website, www.HealthIT.gov creates dedicated consumer-oriented information that describes the benefits of health IT, provides consumer health education materials and will be a valuable resource for learning about new advances in health IT.

For more information about the proposed amendments to the CLIA and HIPAA Privacy regulations, please visit https://www.cms.gov/apps/media/fact_sheets.asp.

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Dec 2011 13:47:10 -0500
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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification -- HHS Releases Essential Health Benefits Bulletin

U.S. House and Senate Notification

Friday, December 16, 2011

To: Congressional Health Staff

From: Jennifer Boulanger

Acting Director, Office of Legislation

Centers for Medicare & Medicaid Services

Re: HHS Releases Essential Health Benefits Bulletin

Today, the Department of Health and Human Services released a bulletin outlining proposed policies that will give states more flexibility and freedom to implement the Affordable Care Act.

The Affordable Care Act ensures that health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges, offer a comprehensive package of items and services, known as “essential health benefits.”

The bulletin released today describes an inclusive, affordable and flexible proposal and informs stakeholders about the approach that HHS intends to pursue in rulemaking to define essential health benefits. HHS is releasing this intended approach to give consumers, states, employers and issuers timely information as they work toward establishing Exchanges and making decisions for 2014. This approach was developed with significant input from the public, as well as reports from the Department of Labor, the Institute of Medicine, and research conducted by HHS.

Under the Department’s intended approach announced today, states would have the flexibility to select an existing health plan to set the “benchmark” for the items and services included in the essential health benefits package. States would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state’s commercial market.

The benefits and services included in the health insurance plan selected by the state would be the essential health benefits package. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. Consistent with the law, states must ensure the essential health benefits package covers items and services in at least ten categories of care, including preventive care, emergency services, maternity care, hospital and physician services, and prescription drugs. If a state selects a plan that does not cover all ten categories of care, the state will have the option to examine other benchmark insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that will be included in the essential health benefits package.

The policy proposed today by HHS would give states the flexibility to select a plan that would be equal in scope to the services covered by a typical employer plan in their state. States and insurers would retain

the flexibility to evolve the benefits package with the market as innovative plan designs are developed and advancements in care become available, and meet the needs of their citizens.

The bulletin issued today addresses only the services and items covered by a health plan, not the cost sharing, such as deductibles, copayments, and coinsurance. The cost-sharing features will be addressed in future bulletins and cost-sharing rules will determine the actuarial value of the plan.

Public input on this proposal is encouraged. Comments are due by January 31, 2012 and can be sent to: EssentialHealthBenefits@cms.hhs.gov.

For the essential health benefits bulletin, visit: <http://cciio.cms.gov/resources/regulations/index.html#hie>

For a fact sheet on the essential health benefits bulletin, visit:
<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

For a summary of individual market coverage as it relates to essential health benefits, visit:
<http://aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.shtml>

For information comparing benefits in small group products and state and Federal employee plans, visit:
<http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml>

If you have questions about this announcement, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 1 Nov 2012 16:29:36 -0400
To: Hunt, Lauren (CMS/CQISO);Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Terri Sewell (rob.nesmith@mail.house.gov);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;Ileana Ros-Lehtinen (golan.rodgers@mail.house.gov);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Sandy Adams (Coleman Garrison);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (keenan.austin@mail.house.gov);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Pastor, Francie);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn)';'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam)';'Price, Tom';'Price, Tom (Emily Henehan)';'Price, Tom (Natalie.Burkhalter@mail.house.gov)';Scott, Austin (Jessica Robertson)';'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (Williams, Bethany)';'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);Katelyn Conner; 'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov)';Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Lee Lilley);Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Howard Coble (meredith.downen@mail.house.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell; 'McHenry, Patrick'; 'McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Teitelbaum, Joshua (Hagan);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Wade, Karen (Hagan)';'Watt, Melvin';Andrae, Taylor (L. Graham);Aramanda, Alec (DeMint)';Clyburn, James';Gowdy, Trey (Beth Webb);Gowdy, Trey (Kam Turner);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Williams, Spencer (L. Graham);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker,

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Releases Final Rule to Implement Increased Medicaid
Primary Care Payments

U.S. House and Senate Notification
Thursday, November 1, 2012

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: HHS Releases Final Rule to Implement Increased Medicaid Primary Care Payments

Today, the Department of Health and Human Services (HHS) released a Final Rule to implement a provision of the Affordable Care Act that increases payment to Medicaid primary care physicians in 2013 and 2014.

The Affordable Care Act provides that certain physicians that provide eligible primary care services will be paid the Medicare rates in effect in calendar years (CY) 2013 and 2014. Increased payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine or related subspecialists. States will receive 100 percent Federal financial participation (FFP) for the difference between the Medicaid State plan payment amount as of July 1, 2009 and the applicable Medicare rate.

Today's Final Rule provides guidance and information about the identification of eligible providers and services and how States can meet the statutory requirements when making these payments for services provided through managed care. The guidance also provides important information on how this policy applies to the Vaccines for Children (VFC) program.

The Final Rule is on display in the Federal Register today, Thursday, November 1, 2012 and can be viewed here

[http://www.ofr.gov/\(X\(1\)S\(inzp4wxrutgayxne1ogtgeqq\)\)/OFRUpload/OFRData/2012-26507_PI.pdf](http://www.ofr.gov/(X(1)S(inzp4wxrutgayxne1ogtgeqq))/OFRUpload/OFRData/2012-26507_PI.pdf). The Final Rule will publish in the Federal Register on November 6, 2012 at which it can be viewed here – <http://www.gpoaccess.gov/fr/>.

Please contact the CMS Office of Legislation if you have any questions about this announcement. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Releases Proposed Notice of Benefit and Payment Parameters

U.S. House and Senate Notification
Friday, November 30, 2012

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: HHS Releases Proposed Notice of Benefit and Payment Parameters

Today, the Department of Health and Human Services (HHS) released a proposed rule that implements key features of the Affordable Care Act. The proposed Notice of Benefit and Payment Parameters expands upon the standards set forth in earlier rules, and provides further information related to policies such as the risk adjustment, reinsurance and risk corridors programs, advance payments of the premium tax credit, and cost-sharing reductions.

Key features of this rule include:

- **Risk Adjustment:** Today we propose a risk adjustment methodology to use when operating risk adjustment on behalf of a state. We also outline our proposed approach to validating risk adjustment data to instill confidence in the program. States that are running an Exchange and their own risk adjustment program can propose a different methodology.
- **Reinsurance:** To improve efficiency and reduce administrative burden, we propose uniform reinsurance payment parameters for this program. A state may supplement the HHS reinsurance payment parameters, but must pay for those supplementary parameters with additional State reinsurance collections or state funds.
- **Risk Corridors:** The temporary risk corridors program protects qualified health plans from uncertainty in rate setting from 2014 to 2016 by having the federal government share risk in losses and gains.
- **Affordability:** The cost-sharing reduction program will further reduce the out-of-pocket spending for health services for low- and middle-income individuals, and Indians. We propose that issuers provide cost sharing reductions at the point of service for eligible individuals and that HHS directly reimburse issuers for these payments.
- **Exchange User Fees:** The rule proposes a user fee for health insurance issuers participating in a Federally-facilitated Exchange that would be commensurate with fees charged by State-based Exchanges.

- **Medical Loss Ratio:** We propose to adjust the medical loss ratio calculation in 2014 to account for Premium Stabilization programs, and adjust the rebate deadline to September 30. We also propose to permit not-for-profit issuers to deduct both community benefit expenditures and state premium tax.

The draft Notice of Benefit and Payment Parameters for 2014 may be viewed here:

http://www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf

If you have questions, please call the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Mar 2015 10:59:15 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Manweiler, Kelsey (Shelby);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Palmer, Gary (Cari Kelly);Paul Winfree (Sessions/Budget);Roby, Martha (Sophie Trainor);Sessions, Jeff (Emily_Mcbride@sessions.senate.gov);Sessions, Jeff (Kim Brown);Sewell, Terri (Hillary Beard);Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Al-Kourainy, Amir (Bill Nelson);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Katie Wise);Clawson, Curt (Jeff Post);Crenshaw, Ander (Catherine Skitsko);Curbelo, Carlos (Ashley Rose);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gittess, David (Bill Nelson);Gram, Gwen (hill.thomas@mail.house.gov);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (Clarey Walker);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (LaTasha Lee);Hastings, Alcee (Mike Sykes);John Mica (Casey.Brinck@mail.house.gov);Jolly, Richard (Ian Manzano);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nugent, Richard (Danielle Doheny);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (Tim Cummings);Rubio, Marco (Eduardo Sacasa);Simon, David (Brown, Corine);Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Dolan, Coby);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Bartolomeo, Jordan (Isakson);Bishop, Sanford (jonathan.halpern@mail.house.gov);Carter, Buddy (chase.cannon@mail.house.gov);Collins, Doug (Jennifer Lackey);Collins, Doug (Vernon Robinson);David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov);David Scott (lauren.lattany@mail.house.gov);Eunice, John (Perdue);Graves, Tom (Bo Butler);Graves, Tom (Rebecca Anderson);Hice, Jody (Michael Calvo);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Lewis, John (Thomas Dorney);Loudermilk, Barry (Easton Randall);Price, Tom (DiBlasio, Carla);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Barr, Andy (Francis Brooke);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);shannon.rickett@mail.house.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Allred, SarahLloyd (Wicker);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Anna Rush);'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Alma (Sandra Brown);Adams, Alma (Shaniqua McClendon);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Coulter, Margaret (HELP Committee));Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Gribble, Kristi);Ellmers, Renee (Mitchell Vakerics);Holding, George (Jason Cooke);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);'McHenry, Patrick';Meadows, Mark (Ansley Rhyne);Pittenger, Robert

(Michelle Jelnicky);Price, David;Rouzer, David (Kyle Sanders);Tillis, Thom (Katy Talento);Tillis, Thom (Ray Starling);Virginia Foxx (Stringer, Meghan);Walker, Mark (Joel Heimbach);'Clyburn, James';Duncan, Jeff (Hilary Ranieri);Gowdy, Trey (Nicholas Spencer);Graham, Lindsey (Jessica Phillips-Tyson);Graham, Lindsey (Nick Myers);Mulvaney, Mick (Natalee Binkholder);Prianti, Marissa (L. Graham);Rice, Tom (Brianna Hewett);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Catherine Phillips);Wilson, Joe (Claire Brandewie);Alexander, Lamar (Alicia_Hennie@help.senate.gov);Black, Diane (Ellen Mailin);Black, Diane (Toomey, Jon);Blackburn, Marsha (Karen Summar);Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (Brittany Hernandez);Cooper, Jim (Ann Waller Curtis);Cooper, Jim (Ashley Shelton);'Corker, Bob';OS Vaughn, Richard;DesJarlais, Scott (Richard Wilkins);Fincher, Stephen (Chris Davis);Fleishmann, Charles;Healy, Jenifer (Corker);John Duncan (patra.stephan@mail.house.gov);Lapinski, MarySumpter (HELP Committee);Phil Roe;Roe, Phil (John Martin);Tatgenhorst, James (Corker) <James_Tatgenhorst@corker.senate.gov>

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Releases Uninsured Brief

U.S. House and Senate Notification

Monday, March 16, 2015

To: Congressional Health Staff

**From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: HHS Releases Uninsured Brief

In advance of the 5th anniversary of the Affordable Care Act, the Department of Health and Human Services (HHS) released a brief detailing the reduction in uninsured. Since passage of the Affordable Care Act, about 16.4 million uninsured people have gained health insurance coverage. That includes:

- About 2.3 million uninsured young adults (aged 19-25) gained health insurance between when the law was enacted in 2010 and October 2013 when the Health Insurance Marketplaces first opened for business. This is due in large part to the provision of the Affordable Care Act that allows young adults to stay on their parents' plans up to age 26.
- An additional 14.1 million uninsured people gained coverage between October 2013 and March 2015 when the Medicaid and Health Insurance Marketplace coverage expansions took effect. That includes 3.4 million young adults. Over that period, the uninsured rate dropped by 35 percent (or a 7.1 percentage point reduction).

The brief can be found here:

http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf

There is also a Technical appendix that can be found here:

http://aspe.hhs.gov/health/reports/2015/uninsured_change/uninsured_technical_notes.pdf

Please contact the CMS Office of Legislation if you have any questions. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 18 Nov 2011 13:57:03 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen)';'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mccconnell.senate.gov;Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James)';Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: Innovation Center Announces Initial Round of Care Transitions Awards

U.S. House and Senate Notification

Friday, November 18, 2011

To: Congressional Health Staff

From: Jennifer Boulanger
Deputy Director, Office of Legislation
Centers for Medicare & Medicaid Services

Subject: Innovation Center Announces Initial Round of Care Transitions Awards

Today, the Center for Medicare and Medicaid Innovation of the Centers for Medicare & Medicaid Services (CMS) announced the first round of awards for the Community-Based Care Transitions Program (CCTP), authorized by Section 3026 of the Affordable Care Act. The CCTP's goals are to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program.

Today's awards went to seven community-based organizations. The CCTP is authorized to spend up to \$500 million through 2015. CMS is continuing to accept applications as funding permits.

The CMS Innovation center will also be holding a conference call **on Tuesday, November 29th**, from **1:00pm-2:30pm**, to allow stakeholders to hear directly from some of the newly selected sites. CMS staff will also be available to answer questions. Call in #: (800) 837-1936 Conference ID: 29693317

The first site selections for the CCTP are available at the link below:

http://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FirstSiteSelections.pdf

For more information, please see the attached factsheet and visit:

<http://www.healthcare.gov/partnershipforpatients> or <http://go.cms.gov/caretransitions>.

Please contact the Office of Legislation if you have any questions at 202-690-8220. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 14 Apr 2011 11:43:10 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Jennifer_Nardi@help.senate.gov);Butterfield, G.K. (Ken.Willis@mail.house.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';'McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Skouras, Spyros)';'Watt, Melvin';Aramanda, Alec (DeMint)';'Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander (marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Integrated Care Demonstrations for Dual Eligibles

U.S. House and Senate Notification
Thursday, April 14, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Integrated Care Demonstrations for Dual Eligibles

Fifteen states across the country have been selected to design new ways to meet the often complex and costly medical needs of the nation's lowest-income and chronically ill citizens. CMS is awarding contracts to provide funding and technical assistance to develop person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for dual eligible individuals.

The 15 States selected to receive contracts are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin. These States are required to engage in significant work with their stakeholder community during the design phase to ensure broad and ongoing stakeholder input on their implementation proposal.

States that actively engage with stakeholders, including beneficiaries and their families, and successfully complete the first design phase may be eligible to receive support to implement their proposals, pending federal approval of the State's demonstration design and the availability of funds. CMS anticipates using lessons learned and best practices from this design phase, as well as the subsequent implementation phase, to assist other States in their efforts to better coordinate care for dual eligible individuals.

Additional information about the Integrated Care for Dually Eligible Individuals Design Contracts will be available at <http://www.cms.gov/dualeligible>.

If you have any questions, please contact the CMS Office of Legislation at 202-690-5519.
Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 11 Dec 2013 09:31:58 -0500
To: Wattenmaker, Lauren (CMS/CQISCO);Bucklen, Kim L. (CMS/CQISCO);CBC Staff;Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Sewell, Terri (Nichole Francis);Young, M.V. (Shelby) <M.V._Young@shelby.senate.gov>;Abby.Dosoretz@mail.house.gov;Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Grayson, Alan (Juan Lopez);Grayson, Alan (Julie Tagen);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Larry Zaragoza);Joe Garcia (Anna Gonzalez);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Katherine Troller);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (jessica.moore@mail.house.gov);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Butler, Bo (Chambliss) <Bo_Butler@chambliss.senate.gov>;Collins, Doug (Jennifer Lackey);David Scott (lauren.lattany@mail.house.gov);Doug Collins (Jason O'Rourke);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston)';'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (Constance Payne);Harper, Gregg (scot.malvaney@mail.house.gov);Marcellino, Elyse (Cochran);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Palazzo, Steven (Marshall Thomas);Stone, Sarah (Cochran) Sarah_Stone@cochran.senate.gov;'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Coulter, Margaret (HELP Committee));Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Ellmers, Renee (Gribble, Kristi);Ellmers, Renee (Josh Babb);Ellmers, Renee (Mitchell Vakerics);Farrar, Elizabeth (Hagan);Hagan, Kay (mike_harney@hagan.senate.gov);Holding, George (Ryan Hart);Howard Coble (meredith.downen@mail.house.gov);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);Mark Meadows (Allison Witt) (allison.witt@mail.house.gov)';McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Meadows, Mark

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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Marketplace Enrollment Report for November

U.S. House and Senate Notification
Wednesday, December 11, 2013

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Marketplace Enrollment Report for November

Health and Human Services (HHS) Secretary Kathleen Sebelius announced today that nearly 365,000 individuals have selected plans from the state and federal Marketplaces by the end of November. November alone added more than a quarter million enrollees in state and federal Marketplaces. Enrollment in the federal Marketplace in November was more than four times greater than October's reported federal enrollment number.

Since October 1, 1.9 million have made it through the eligibility process, by applying and receiving an eligibility determination, but have not yet selected a plan. An additional 803,077 were determined or assessed eligible for Medicaid or the Children's Health Insurance Program (CHIP) in October and November by the Health Insurance Marketplace.

The HHS issue brief highlights the following key findings, which are among many newly available data reported today on national and state-level enrollment-related information:

- November's federal enrollment number outpaced the October number by more than four times.
- Nearly 1.2 million Americans, based only on the first two months of open enrollment, have selected a plan or had a Medicaid or CHIP eligibility determination;
 - Of those, 364,682 Americans selected plans from the state and federal Marketplaces; and

- 803,077 Americans were determined or assessed eligible for Medicaid or CHIP by the Health Insurance Marketplace.
- 39.1 million visitors have visited the state and federal sites to date.
- There were an estimated 5.2 million calls to the state and federal call centers.

The report groups findings by state and federal marketplaces. In some cases only partial datasets were available for state marketplaces. The report features cumulative data for the two month period because some people apply, shop, and select a plan across monthly reporting periods. These counts avoid potential duplication associated with monthly reporting

To read today's report visit:

http://aspe.hhs.gov/health/reports/2013/MarketPlaceEnrollment/Dec2013/ib_2013dec_enrollment.pdf

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 22 Dec 2015 16:57:07 -0500
To: Howell, Cherie A. (CMS/OL);Rep. Young;Sen. Murkowski;Sen. Sullivan;Sen. Sullivan;Rep. Womack;Rep. Crawford;Rep. Crawford;Rep. Hill;Rep. Westerman;Sen. Boozman;Sen. Cotton (Brian_colas@cotton.senate.gov);Rep. Labrador (Aaron.calkins@mail.house.gov);Rep. Simpson;Sen. Crapo;Sen. Risch (Rachel_burkett@risch.senate.gov);Rep. Abraham;Rep. Boustany;Rep. Boustany;Rep. Fleming;Rep. Garret Graves;Rep. Graves;Rep. Richmond;Rep. Scalise;Sen. Cassidy;Sen. Vitter;Rep. Lujan;Rep. Lujan;Rep. Lujan;Rep. Lujan (Jeffery.bustamante@mail.house.gov);Rep. Lujan Grisham;Rep. Lujan Grisham;Rep. Pearce;Rep. Pearce (Patrick.cuff@mail.house.gov);Sen. Heinrich;Sen. Udall;Rep. Bridenstine (mark.piland@mail.house.gov);Rep. Cole;Rep. Lucas;Rep. Mullin (Adam.Buckalew@mail.house.gov);Rep. Russell;Sen. Inhofe;Sen. Lankford (Katherine_Mayne@lankford.senate.gov);Rep. Blumenauer;Rep. Bonamici;Rep. Bonamici;Rep. Defazio;Rep. DeFazio (kris.pratt@mail.house.gov);Rep. Schrader;Rep. Walden;Rep. Blumenauer;Sen. Merkley (Susan_Lexer@merkle.senate.gov);Sen. wyden;Rep O'Rourke;Rep. AL Green;Rep. Babin;Rep. Babin;Rep. Barton;Rep. Brady;Rep. Brady;Rep. Burgess;Rep. castro;Rep. Conaway;Rep. Cuellar (Ryan.Ehly@mail.house.gov);Rep. Culberson;Rep. Culberson;Rep. Doggett;Rep. Doggett;Rep. Eddie Bernice Johnson;Rep. Farenthold;Rep. Flores;Rep. Gene Green;Rep. Gohmert;Rep. Granger;Rep. Hensarling;Rep. Hinojosa;Rep. Hurd;Rep. Jackson Lee;Rep. Marchant;Rep. McCaul;Rep. Neugebauer;Rep. Olson;Rep. Orourke;Rep. Poe;Rep. Ratcliffe;Rep. Sam Johnson;Rep. Sessions (elle.ross@mail.house.gov);Rep. Smith;Rep. Smith;Rep. Thornberry;Rep. Veasey (kenny.palmer@mail.house.gov);Rep. Vela (jasey.cardenas@mail.house.gov);Rep. Weber;Rep. Williams;Sen. Cornyn;Sen. cornyn;Sen. Cruz;Rep. Adam Smith;Rep. Delbene;Rep. Heck;Rep. Heck;Rep. Heck;Rep. Heck;Rep. Herrera;Rep. Kilmer;Rep. Larsen (matt.renninger@mail.house.gov);Rep. McDermott;Rep. McMorris Rodgers;Rep. Newhouse;Rep. Reichert;Sen. Cantwell;Sen. Cantwell;Sen. Murray (madeleine_pannell@help.senate.gov)
Cc: Chadwick, Alpheus K. (CMS/OL);Saklas, Ariadne (CMS/OL)
Subject: Hill Notification: Medicare Advantage Part C Recovery Auditor Request for Information

U.S. House and Senate Notification
Tuesday, December 22, 2015

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Medicare Advantage Part C Recovery Auditor Request for Information

The Centers for Medicare & Medicaid Services (CMS) today released a Request for Information (RFI) related to CMS entering into a contract with one or more Recovery Auditors to identify and correct overpayments and underpayments in Medicare Part C. Included in the RFI package is a draft Statement of Work, under which CMS would contract with a Recovery Auditor to significantly expand the agency's current Medicare Advantage Risk Adjustment Data Validation (RADV) audit initiative and to conduct additional audits of diagnosis data submitted to CMS by Medicare Advantage Organizations. CMS is seeking feedback from potential contractors

regarding the draft Statement of Work and the level of contractor interest and capability to conduct on this type of work. Comments are due Monday, February 1, 2016.

The RFI will be available online, here:

https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3ffbc5d&tab=core&_cvview=0.

If you have any questions, please contact the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 30 Nov 2011 07:55:06 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Sandy Adams (Coleman Garrison);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mccconnell.senate.gov;Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);Wade, Karen (Hagan);'Watt, Melvin';Aramanda, Alec (DeMint);'Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Medicare Covers Screening and Counseling for Obesity
Attachments: Press Release 11 11 29 ObesityConsult NCD FINAL.PDF

U.S. House and Senate Notification
Wednesday, November 30, 2011

To: Congressional Health Staff

From: Jennifer Boulanger
Acting Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Medicare Covers Screening and Counseling for Obesity

Yesterday, the Centers for Medicare & Medicaid Services (CMS) announced that Medicare is adding coverage for preventive services to reduce obesity. This adds to Medicare's existing portfolio of preventive services that are now available without cost-sharing under the Affordable Care Act. It also complements the *Million Hearts* initiative led jointly by CMS and the Centers for Disease Control and Prevention along with other HHS agencies and public- and private-sector partners across the country to prevent one million heart attacks and strokes in the next 5 years.

Over 30 percent of both men and women in the Medicare population are estimated to be obese. Obesity is directly or indirectly associated with many chronic diseases, including those that disproportionately affect racial and ethnic minorities such as cardiovascular disease and diabetes. Addressing the prevention of obesity-related disparities has the potential to reduce obesity prevalence while also closing the gap on health disparities among Medicare beneficiaries.

The new benefit covers screening for obesity and counseling for eligible beneficiaries by primary care providers. A beneficiary who screens positive for obesity with a body mass index (BMI) ≥ 30 kg/m² may receive one face-to-face counseling visit each week for one month and one face-to-face counseling visit every other week for an additional five months. Further monthly counseling visits will be covered for an additional six months (for a total of 12 months of counseling) if the beneficiary has lost at least 6.6 pounds during the first six months of counseling.

The National Coverage Determination is available on the CMS Coverage website at <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253&>. A press release on today's announcement is also attached, FYI.

Information on the *Million Hearts* campaign is available at www.millionhearts.hhs.gov.

If you have any questions, please contact the CMS Office of Legislation.



MEDICARE NEWS

FOR IMMEDIATE RELEASE

November 29, 2011

Contact: CMS Media Relations Group

(202) 690-6145

Medicare covers screening and counseling for obesity

Decision adds a new preventive service for Medicare beneficiaries

The Centers for Medicare & Medicaid Services (CMS) today announced that Medicare is adding coverage for preventive services to reduce obesity. This adds to Medicare's existing portfolio of preventive services that are now available without cost sharing under the Affordable Care Act. It complements the *Million Hearts* initiative led jointly by CMS and the Centers for Disease Control and Prevention in partnership with other HHS agencies, communities, health systems, nonprofit organizations, and private sector partners across the country to prevent one million heart attacks and strokes in the next 5 years.

"Obesity is a challenge faced by Americans of all ages, and prevention is crucial for the management and elimination of obesity in our country," said CMS Administrator Donald M. Berwick, MD. "It's important for Medicare patients to enjoy access to appropriate screening and preventive services."

Over 30% of both men and women in the Medicare population are estimated to be obese. Obesity is directly or indirectly associated with many chronic diseases, including those that disproportionately affect racial and ethnic minorities such as cardiovascular disease and diabetes. Addressing the prevention of obesity related disparities has the potential to reduce obesity prevalence while also closing the gap on health disparities among Medicare beneficiaries.

Screening for obesity and counseling for eligible beneficiaries by primary care providers in settings such as physicians' offices are covered under this new benefit. For a beneficiary who screens positive for obesity with a body mass index (BMI) ≥ 30 kg/m², the benefit would include one face-to-face counseling visit each week for one month and one face-to-face counseling visit every other week for an additional five months. The beneficiary may receive one face-to-face counseling visit every month for an additional six months (for a total of 12 months of counseling) if he or she has achieved a weight reduction of at least 6.6 pounds (or 3 kilograms) during the first six months of counseling.

"This decision is an important step in aligning Medicare's portfolio of preventive services with evidence and addressing risk factors for disease," said Patrick Conway, MD, MSc, CMS Chief Medical Officer and Director of the Agency's Office of Clinical Standards and Quality. "We at CMS are carefully and systematically reviewing the best available medical evidence to identify those preventive services that can keep Medicare beneficiaries as healthy as possible for as long as possible."

Through the end of October, 22.6 million people with Original Medicare have received one or more of the free covered preventive services this year.

To read the final decision on the new national coverage determination, visit the CMS website at: <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAIAAA&NCAId=253&>

For more information about *Million Hearts*, please visit millionhearts.hhs.gov.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 30 Jul 2013 16:38:40 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Terri Sewell (rob.nesmith@mail.house.gov);Young, M.V. (Shelby) <M.V._Young@shelby.senate.gov>;Abby.Dosoretz@mail.house.gov;Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Grayson, Alan (Juan Lopez);Grayson, Alan (Julie Tagen);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Larry Zaragoza);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Katherine Troller);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (jessica.moore@mail.house.gov);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (garrett.bess@mail.house.gov);Wilson, Frederica (keenan.austin@mail.house.gov);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Butler, Bo (Chambliss) <Bo_Butler@chambliss.senate.gov>;Collins, Doug (Jennifer Lackey);David Scott (lauren.lattany@mail.house.gov);Doug Collins (Jason O'Rourke);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Pastor, Francie);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);Stone, Sarah (Cochran) Sarah_Stone@cochran.senate.gov;'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);Thompson, Bennie (TSMITH@mail.house.gov);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Ellmers, Renee (Josh Babb);Ellmers, Renee (Mitchell Vakerics);Hagan, Kay (mike_harney@hagan.senate.gov);Holding, George (Ryan Hart);Howard Coble (meredith.downen@mail.house.gov);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);Mark Meadows (Allison Witt) (allison.witt@mail.house.gov);'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Meadows, Mark

(Patrick Fleming);Pittenger, Robert (Michelle Jelnick);Price, David;Teitelbaum, Joshua (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Stringer, Meghan);Wade, Karen (Hagan);'Watt, Melvin';Andreae, Taylor (L. Graham);'Clyburn, James';Duncan, Jeff (Hilary Ranieri);Gowdy, Trey (Beth Webb);Gowdy, Trey (Kam Turner);Graham, Lindsey (colin_allen@lgraham.senate.gov);Joe Wilson (melissa.murphy@mail.house.gov);Mulvaney, Mick (Matt Carter);ONEill, Tara (Tara.ONEill2@mail.house.gov);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Catherine Phillips);Williams, Spencer (L. Graham);Alexander, Lamar (Alicia_Hennie@help.senate.gov);Bassett, Michael (Corker) <Michael_Bassett@corker.senate.gov>;Black, Diane (Emily Wilkinson);Blackburn, Marsha (Studdard, Keith);Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (Paul Shorkey);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Healy, Jenifer (Corker);John Duncan (patra.stephan@mail.house.gov);Lapinski, MarySumpter (HELP Committee);Phil Roe;Tatgenhorst, James (Corker) <James_Tatgenhorst@corker.senate.gov>
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Medicare Drug Premiums Remain Stable Four Years in a Row

U.S. House and Senate Notification
Tuesday, July 30, 2013

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Medicare Drug Premiums Remain Stable Four Years in a Row

On the 48th anniversary of the signing of Medicare and Medicaid into law, the Centers for Medicare & Medicaid Services (CMS) released data showing that the average premium for a basic prescription drug plan in 2014 is projected to remain stable, at an estimated \$31 per month. For the last three years – for plan years 2011, 2012, and 2013 – the average premium was projected to be \$30. Today’s projection for the average premium for 2014 is based on bids submitted by drug and health plans for basic drug coverage during the 2014 plan year.

CMS has already announced that key parameters for Part D will actually be lower in 2014 than in 2013. For example, the Part D deductible will fall from \$325 to \$310, producing additional savings for enrollees.

The upcoming annual open enrollment period - which begins October 15 and ends December 7 - allows people with Medicare, working with their families and their caregivers, to choose their plans for next year by comparing their current coverage and quality ratings to other plan offerings. New benefit choices are effective Jan. 1, 2014.

This news comes as seniors and people with disabilities continue to save money on out of pocket drug costs. Yesterday, CMS announced that more than 6.6 million people with Medicare have

saved over \$7 billion on prescription drugs as a result of the Affordable Care Act, an average of \$1,061 per beneficiary.

Today's press release is available at: <http://www.hhs.gov/news/>

Kathleen Sebelius', Secretary of Health and Human Services, blog on the 48th Anniversary of Medicare and Medicaid is available at:

<http://www.hhs.gov/healthcare/facts/blog/2013/07/medicare-helps-millions.html>

If you have any questions regarding today's announcement, please contact the CMS Office of Legislation. Thank you.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 7 Jul 2011 16:52:45 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: Medicare Expands Coverage of MRI Exams for Patients with FDA-Approved Pacemakers

Attachments: MRIPRFinal .pdf

U.S. House and Senate Notification

Thursday, July 7, 2011

To: Congressional Health Staff

From: Amy Hall

Director, Office of Legislation

Centers for Medicare & Medicaid Services

Re: Medicare Expands Coverage of MRI Exams for Patients with FDA-Approved Pacemakers

The Centers for Medicare & Medicaid Services (CMS) today expanded Medicare coverage of Magnetic Resonance Imaging (MRI) for beneficiaries with implanted pacemakers when used according to FDA-approved labeling in an MRI environment. A final National Coverage Determination (NCD) posted today provides access to the MRI environment for patients with FDA-approved pacemakers.

The final coverage policy issued today follows a proposed decision issued in April 2011. The final decision memorandum is available on the CMS website at www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=252&fromdb=true.

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220.
Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201
Office of Communications



MEDICARE NEWS

FOR IMMEDIATE RELEASE
July 7, 2011

Contact: CMS Media Relations Group
(202) 690-6145

Medicare expands coverage for patients with pacemakers that are FDA-approved for use with MRI exams

The Centers for Medicare & Medicaid Services (CMS) today expanded Medicare coverage of Magnetic Resonance Imaging (MRI) for beneficiaries with implanted pacemakers when used according to FDA-approved labeling in an MRI environment. A final National Coverage Determination (NCD) posted today provides access to the MRI environment for patients with FDA-approved pacemakers.

On February 8, the Food and Drug Administration (FDA) approved the RevoMRI SureScan Pacing System, which is designed for use in the MRI environment for certain MRI exams. Currently, there are no other pacemakers or implantable cardioverter defibrillators that are FDA-approved for use in the MRI environment.

“This swift action by CMS provides patients who need a pacemaker with greater access to MRI exams,” said Donald M. Berwick, M.D., CMS administrator. “The expedited review of this decision demonstrates our commitment and support of new technology that will help improve the health of our beneficiaries.”

MRI is a noninvasive method of imaging that has the capability of demonstrating a wide variety of soft-tissue lesions in various parts of the body. It is used to diagnose many medical conditions, such as cancer, and is used to look at various parts of the body, including the head, central nervous system, and the spine. MRI also has advantages over other imaging techniques such as computed tomography (CT) and conventional radiographs, including no radiation exposure and easier visibility of soft tissue.

However, MRI exposes the patient to high magnetic and radio-frequency fields that may cause the movement or heating of implanted medical devices that are ferromagnetic (e.g. surgical clips)

or that have ferromagnetic components (e.g. pacemakers, prostheses). The American College of Radiology's (ACR) guidance document on safe MRI Practices (Kanal, 2007) explicitly discusses the need to address potential risks of exposure for patients that may have ferromagnetic foreign bodies or implants.

The final coverage policy issued today follows a proposed decision issued in April 2011. The final decision memorandum is available on the CMS website at [https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Magnetic%20Resonance%20Imaging%20\(MRI\)%20\(3rd%20Recon\)&bc=ACAAA AAAIAAA&NCAId=252&](https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Magnetic%20Resonance%20Imaging%20(MRI)%20(3rd%20Recon)&bc=ACAAA AAAIAAA&NCAId=252&).

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 28 Nov 2011 10:59:05 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Diaz-Balart, Mario;John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Miller, Jeff (diane.cihota@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);Sandy Adams (Coleman Garrison);Southerland, Steve;PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (sarah.curtis@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mccconnell.senate.gov;Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);Wade, Karen (Hagan);'Watt, Melvin';Aramanda, Alec (DeMint);'Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Medicare's Dec. 7th Open Enrollment Deadline Nears
Attachments: 11 11 28 OE Reminder Release FINAL 3.pdf

U.S. House and Senate Notification
Monday, November 28, 2011

To: Congressional Health Staff

From: Jennifer Boulanger
Deputy Director, Office of Legislation
Centers for Medicare & Medicaid Services

Subject: Medicare's Dec. 7th Open Enrollment Deadline Nears

As the December 7th deadline grows closer for people with Medicare to change or choose their drug and health plan coverage for next year, the Centers for Medicare and Medicaid Services and its network of partners and advocates are available to assist with counseling and enrolling beneficiaries on their choices for 2012. With just weeks remaining in the Annual Enrollment Period, Medicare's popular consumer resources – www.medicare.gov and 1-800-MEDICARE – are assisting beneficiaries, their families, partners and trusted representatives.

CMS recently mailed Medicare & You handbooks and postcards to more than 42 million households reminding them of the December 7th deadline.

Nationally, enrollment opportunities are available:

- **Online:** Since the beginning of Open Enrollment (October 15), online activities have surpassed 26 million page views across the Medicare Plan Finder web tool and open enrollment sections of www.Medicare.gov.
- **On the phone:** 1-800-MEDICARE (1-800-633-4227) continues to be an important 24/7 resource for personalized assistance during Open Enrollment. More than 3.4 million calls have been handled and wait times continue to fall within acceptable customer service thresholds.
- **Face-to-face:** At Open Enrollment events across the country, Medicare has been working closely with its partners across the nation to provide counseling opportunities for people with Medicare in their home communities.

A press release is attached. Please contact the Office of Legislation at 202-690-8220 if you have any questions. Thank you.



MEDICARE NEWS

FOR IMMEDIATE RELEASE
November 28, 2011

CONTACT: CMS Media Affairs
(202) 690-6145

Medicare's Dec. 7th Open Enrollment deadline nears
*Ongoing resources are available for seniors and people with disabilities
to compare coverage options*

As the December 7th deadline grows closer for people with Medicare to change or choose their drug and health plan coverage for next year, the Centers for Medicare and Medicaid Services and its network of partners and advocates are available to assist with counseling and enrolling beneficiaries on their choices for 2012. With just weeks remaining in the Annual Enrollment Period, Medicare's popular consumer resources – www.medicare.gov and 1-800-MEDICARE – are assisting beneficiaries, their families, partners and trusted representatives.

“Seniors and people with Medicare should act now, review their plan coverage and compare their current plan with other available options,” said CMS Administrator Donald M. Berwick, M.D. “The important decisions you make now can help ensure that any changes made will be in place by January 2012 for seamless and uninterrupted access to your healthcare providers and medications at your chosen pharmacies.”

CMS recently mailed Medicare & You handbooks and postcards to more than 42 million households reminding them of the December 7th deadline. This year, as beneficiaries look over their available plan options, they will see better value in the Medicare Advantage (Part C) and Prescription Drug (Part D) plan benefits. Medicare Advantage enrollees are now assured of the same access as other Medicare beneficiaries to certain Medicare-covered preventive services at zero cost-sharing, including an Annual Wellness Visit. On average, Medicare Advantage premiums will be four percent lower in 2012 than in 2011, and plans expect enrollment to increase by 10 percent.

Beneficiaries with Part D coverage who are in the coverage gap, or “donut hole,” will continue to receive 50 percent discounts on covered brand name drugs thanks to the Affordable Care Act. Beneficiaries have seen an average savings of \$581 on covered brand name drugs, and an additional \$22 in savings on generic drugs – yet another reason to compare and choose the drug plan that best fits a patient's needs. Average premiums for Part D prescription drug plans will also decrease to \$30 in 2012, about 76 cents less compared to the average 2011 premium. The premium amount is based on bids submitted by Part D plans for the 2012 plan year. Benefits in 2012 remain consistent with those offered in 2011.

“Before the December 7th deadline, we urge all people with Medicare to focus on Open Enrollment and compare costs, coverage and their satisfaction with their current coverage with options for 2012,” Berwick said. “Once you compare plans, if your current plan satisfies your needs for next year, you don’t need to do anything. If other options are a better match for your needs, there is still time to change.”

Medicare’s Open Enrollment season continues to generate high levels of activity on 1-800-MEDICARE with our unbiased customer service agents, and our popular web-based resource: www.medicare.gov. People with Medicare and their trusted representatives have used the web-resources from their homes or at counseling events around the country. Nationally, enrollment opportunities are available:

- **Online:** Since the beginning of Open Enrollment (October 15) , online activities have surpassed 26 million page views across the Medicare Plan Finder web tool and open enrollment sections of www.Medicare.gov.
- **On the phone:** 1-800-MEDICARE (1-800-633-4227) continues to be an important 24/7 resource for personalized assistance during Open Enrollment. More than 3.4 million calls have been handled and wait times continue to fall within acceptable customer service thresholds.
- **Face-to-face:** At Open Enrollment events across the country, Medicare has been working closely with its partners across the nation to provide counseling opportunities for people with Medicare in their home communities. More than a thousand events with Medicare beneficiaries have been held across the country – and thousands of SHIP counseling sessions have been conducted. CMS and its partners have shared unbiased drug and health plan information at senior activity centers, through education-oriented media partnerships and phone banks and with other advocacy partners in unique local venues and faith-based communities. These events also highlight Medicare’s preventive services, including flu and pneumococcal shots and health screenings. For more information contact your local Area Agency on Aging, State Health Insurance Program or other unbiased senior advocacy organizations. Contact information for local telephone or face-to-face enrollment resources and year round assistance can be found on the back pages of your Medicare & You handbook.

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 17 Jun 2011 15:18:46 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Brooks, Mo (seibenhener, lance);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Palazzo, Steven (Spencer Wayne);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Ken.Willis@mail.house.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';'McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);'Watt, Melvin';Aramanda, Alec (DeMint);'Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan

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(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: New Annual Limits Waiver Guidance and Data

U.S. House and Senate Notification
Friday, June 17, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: New Annual Limits Waiver Guidance and Data

Today, the Centers for Medicare & Medicaid Services (CMS) issued guidance to allow limited benefit plans to apply for or renew a temporary waiver from annual limit restrictions through 2013. In 2014, annual limits for new health plans will be banned as high-quality, affordable, and comprehensive health insurance plans are made available through Health Insurance Exchanges. Until then, annual limits are gradually phased out in order to preserve access to needed benefits and the affordability of coverage. CMS has granted temporary waivers from the annual limits provision of the law for plans that demonstrate that compliance with the gradual phase-out of limits would result in a significant decrease in access to benefits or a significant increase in premiums.

CMS announced today that, after September 22, 2011, no new applications or requests for extensions will be considered.

Today's guidance imposes new, more stringent disclosure requirements and requires health plans with waivers to tell consumers that their health care coverage is subject to an annual dollar limit lower than what is allowed under the law. Insurers also must include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies. Plans also must show how the annual limit would affect a consumer who was hospitalized to help people understand how far their coverage will reach if they become seriously ill. Finally, plans with waivers must attest annually to their compliance with the consumer disclosure requirement.

In addition, CMS today released updated lists of insurance plans whose applications for a waiver have been approved or denied. That information is available by city and state at cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

For more information about how the Affordable Care Act is helping protect consumers by phasing out annual limits, visit www.HealthCare.gov/law/provisions/limits/limits.html. For more information about today's announcement, visit www.HealthCare.gov/news/factsheets/annuallimit06172011a.html.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 17 Dec 2013 09:44:59 -0500
To: Wattenmaker, Lauren (CMS/CQISCO);Bucklen, Kim L. (CMS/CQISCO);CBC Staff;Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Sewell, Terri (Nichole Francis);Young, M.V. (Shelby) <M.V._Young@shelby.senate.gov>;Abby.Dosoretz@mail.house.gov;Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Grayson, Alan (Juan Lopez);Grayson, Alan (Julie Tagen);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (Larry Zaragoza);Joe Garcia (Anna Gonzalez);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Katherine Troller);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (jessica.moore@mail.house.gov);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Butler, Bo (Chambliss) <Bo_Butler@chambliss.senate.gov>;Collins, Doug (Jennifer Lackey);David Scott (lauren.lattany@mail.house.gov);Doug Collins (Jason O'Rourke);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (Constance Payne);Harper, Gregg (scot.malvaney@mail.house.gov);Marcellino, Elyse (Cochran);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Palazzo, Steven (Marshall Thomas);Stone, Sarah (Cochran) Sarah_Stone@cochran.senate.gov;'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Coulter, Margaret (HELP Committee));Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Ellmers, Renee (Gribble, Kristi);Ellmers, Renee (Josh Babb);Ellmers, Renee (Mitchell Vakerics);Farrar, Elizabeth (Hagan);Hagan, Kay (mike_harney@hagan.senate.gov);Holding, George (Ryan Hart);Howard Coble (meredith.downen@mail.house.gov);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);Mark Meadows (Allison Witt) (allison.witt@mail.house.gov);'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Meadows, Mark

(Patrick Fleming);Pittenger, Robert (Michelle Jelnick);Price, David;Teitelbaum, Joshua (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Stringer, Meghan);'Watt, Melvin';Andreae, Taylor (L. Graham);'Clyburn, James';Duncan, Jeff (Hilary Ranieri);Gowdy, Trey (Beth Webb);Gowdy, Trey (Kam Turner);Graham, Lindsey (colin_allen@lgraham.senate.gov);Joe Wilson (melissa.murphy@mail.house.gov);Mulvaney, Mick (Matt Carter);Rice, Tom (Brianna Hewett);Rice, Tom (Courtney Titus);Sanford, Mark (Justin Ouimette);Scott, Tim (Catherine Phillips);Williams, Spencer (L. Graham);Alexander, Lamar (Alicia_Hennie@help.senate.gov);Bassett, Michael (Corker) <Michael_Bassett@corker.senate.gov>;Black, Diane (Ellen Mailin);Black, Diane (Emily Wilkinson);Blackburn, Marsha (Studdard, Keith);Charles Fleishmann (jim.hippe@mail.house.gov);Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (Paul Shorkey);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Healy, Jenifer (Corker);John Duncan (patra.stephan@mail.house.gov);Lapinski, MarySumpter (HELP Committee);Phil Roe;Tatgenhorst, James (Corker) <James_Tatgenhorst@corker.senate.gov>
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: New CMS Data on Medicare Use of Preventive Services
Attachments: Press Release Preventive Services Dec 17 2013.pdf

U.S. House and Senate Notification
Tuesday, December 17, 2013

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: New CMS Data on Medicare Use of Preventive Services

Today, the Centers for Medicare & Medicaid Services (CMS) released new data showing that during the first eleven months of 2013, over 25.4 million people with Original Medicare received at least one preventive service at no cost to them and over 3.5 million took advantage of the Annual Wellness Visit established by the Affordable Care Act. In contrast, during the same time period in 2012, an estimated 24.7 million people with Original Medicare received one or more preventive services with no out-of-pocket costs, and almost 2.76 million received an Annual Wellness Visit.

Prior to the Affordable Care Act, Medicare beneficiaries had to pay part of the cost for many preventive health services. Under the Affordable Care Act, many preventive services are offered at no cost to beneficiaries (with no deductible or co-pay), so that cost is no longer a barrier for seniors who want to stay healthy and treat problems early.

A press release on today's announcement is attached. State-by-state information on the use of free preventive services in Original Medicare is also available at:
http://downloads.cms.gov/files/Preventive_Services_Utilization_by_State_Jan-Nov_2013.pdf.

If you have any questions, please contact the CMS Office of Legislation at 202-690-8220.
Thank you.

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CMS NEWS

FOR IMMEDIATE RELEASE
December 17, 2013

Contact: CMS Media Relations
(202) 690-6145 | press@cms.hhs.gov

More than 25 million Original Medicare beneficiaries received free preventive services through November 2013

According to new data released by the Centers for Medicare & Medicaid Services (CMS) today, more than 25.4 million people covered by Original Medicare received at least one preventive service at no cost to them during the first eleven months of 2013, because of the Affordable Care Act. Today's news comes after last month's announcement showing that the health care law also saved seniors \$8.9 billion on their prescription drugs since the law's enactment.

“Thanks to the Affordable Care Act, millions of seniors have been able to receive important preventive services and screenings such as an annual wellness visit, screening mammograms and colonoscopies, and smoking cessation at no cost to them,” said CMS Administrator Marilyn Tavenner. “Prevention and early detection are so vital to ensure that Americans are healthy and Medicare is healthy. The Affordable Care Act makes Medicare stronger and improves the wellbeing of millions of beneficiaries who have taken advantage of preventive services and wellness visits.”

Today's announcement exceeds the comparable figure from last November, when an estimated 24.7 million people with Original Medicare received one or more preventive benefits at no out of pocket costs by this point in time during 2012. When factoring in Medicare Advantage utilization rates and a full year of experience, an estimated 34.1 million people with Medicare took advantage of at least one preventive service in 2012. Moreover, in the first eleven months of 2013, more than 3.5 million beneficiaries with Original Medicare took advantage of the Annual Wellness Visit established by the health care law – a significant increase from the 2.8 million who used this service by this point in the year in 2012.

Before the Affordable Care Act, Medicare recipients had to pay part of the cost for many preventive health services. These out-of-pocket costs made it difficult for people to get the important preventive care they needed. For example, before the Affordable Care Act, a person with Medicare could pay as much as \$160 in cost-sharing for a colorectal cancer screening. Today, this important screening and

many others are covered at no cost to beneficiaries (with no deductible or co-pay). The Affordable Care Act helps tear down a significant barrier for some seniors to staying healthy and helps their care providers prevent, identify and treat problems early.

For state-by-state information on utilization of free preventive services for people with original Medicare, please visit: http://downloads.cms.gov/files/Preventive_Services_Utilization_by_State_Jan-Nov_2013.pdf

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 18 Dec 2014 14:42:42 -0500
To: Bucklen, Kim L. (CMS/CQISCO);CBC Staff;Howell, Cherie A. (CMS/OL);Davis, Stephanie M. (CMS/CQISCO);Wattenmaker, Lauren (CMS/CQISCO);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Byrne, Bradley (Lora Hobbs);Byrne, Bradley (Matt Weinstein);Gregory Dangelo (Sessions/Budget);Hankey, Mary Blanche (Sessions);Manweiler, Kelsey (Shelby);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];Paul Winfree (Sessions/Budget);Sewell, Terri (Hillary Beard);Shelby, Richard (Jay Dunn);Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Al-Kourainy, Amir (Bill Nelson);Bilirakis, Gus;Bilirakis, Gus (Power, Thomas);Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Buchanan, Vern (Katie Wise);Clawson, Curt (Jeff Post);Crenshaw, Ander;Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Gittess, David (Bill Nelson);Grayson, Alan (Shilpa Finnerty);Hastings, Alcee (David Opong-Wadee);Hastings, Alcee (LaTasha Lee);Hastings, Alcee (Mike Sykes);Joe Garcia (Anna Gonzalez);John Mica (Casey.Brinck@mail.house.gov);Jolly, David (LJ Govoni);Miller, Jeff (diane.cihota@mail.house.gov);Miller, Jeff (Spencer Orenstein);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Laura Cooper);Posey, Bill;Ron DeSantis (Rachel Dresen);Rooney, Tom (Andrew Callahan);Rooney, Tom (jessica.moore@mail.house.gov);Rose-Lehtinen, Ileana (Brooks, Wes);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Eduardo Sacasa);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (James Walsh);Wasserman Schultz, Debbie (Dolan, Coby);Wasserman Schultz, Debbie (Sarah Arkin);Webster, Daniel (garrett.bess@mail.house.gov);Webster, Daniel (Tyrrell, Andrew);Wilson, Frederica (keenan.austin@mail.house.gov);'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (Bobby McMillin);Collins, Doug (Jennifer Lackey);Collins, Doug (Vernon Robinson);David Scott (lauren.lattany@mail.house.gov);Graves, Tom (Bo Butler);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Chance Phiniezy);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Maureen Rhodes);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);Price, Tom (Amanda Street);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Burkhalter, Natalie (Paul);Conklin, Jennifer (McConnell);Guthrie, Brett (Megan Spindel);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (John Gray);Paul, Rand (Rachel Bovard);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Yarmuth, John (Marshall, Zack);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (Constance Payne);Harper, Gregg (Jordan See);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Nunnelee, Alan (Tara Morgan);Palazzo, Steven (Marshall Thomas);'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Coulter, Margaret (HELP Committee));Butterfield, G.K. (Britton, Cammie);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Butterfield, G.K. (Okey Enyia);Butterfield, G.K. (Taylor, Annette);Ellmers, Renee (Gribble, Kristi);Ellmers, Renee (Mitchell Vakerics);Farrar, Elizabeth

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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Physician Compare/Hospital Compare/HAC Data Posting/VBP Payment Adjustments
Attachments: Phys-Hosp Compare Fact Sheet 12-18-2014-FINAL.PDF, HACRP HVBP Public Reporting Fact Sheet 12 18 14-FINAL.PDF

U.S. House and Senate Notification
Thursday, December 18, 2014

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Physician Compare/Hospital Compare/HAC Data Posting/VBP Payment Adjustments

The Centers for Medicare & Medicaid Services (CMS) today updated and added data on new quality measures to the Hospital Compare website and added new quality data to the Physician Compare website. In addition, CMS posted results online of the first year of the Hospital Acquired Condition (HAC) Reduction program and third year results under the hospital Value-Based Purchasing program. These data updates and releases include the following –

- Hospital Compare provides information on over 4,000 hospitals, and information is updated on a quarterly basis. Some of the measures being reported for the first time are: the Care Transition survey measure; the Healthcare Provider Influenza measure; the 30-day risk-standardized mortality and readmission rates for COPD and stroke; the 30 day episode of care payment measure for heart attack patients; and two measures under the for PPS-Exempt Cancer Hospital Quality Reporting program.

- The first quality measures were added to Physician Compare in February 2014. Today, CMS added to the website certain measures reported under the 2013 Physician Quality Reporting System Group Practice Reporting Option for 139 group practices, 214 Shared Savings Program Accountable Care Organizations (ACOs), and 23 Pioneer ACOs. The measures being reported include a subset of Diabetes measures and Coronary Artery Disease measures, and additionally for ACOs, four patient experience of care survey measures. As with the earlier posting of measures, this information is being displayed on Physician Compare using stars, and followed by a percentage score.
- The scores from the first year of the HAC Reduction program, which is required by section 3008 of the Affordable Care Act, are being posted online. This program requires that beginning in FY 2015, hospitals that rank in the top quartile with respect to hospital-acquired conditions will have their payment reduced by 1 percent for all discharges during the fiscal year. Hospital performance under the HAC Reduction Program is determined based on specified patient safety and healthcare-associated infection measures and a scoring methodology determined through notice and comment rulemaking. The results for FY 2015 were calculated under this program, and hospitals were given a chance to review their data and request a recalculation of their scores if they believed an error was made. Based on the total performance scores, approximately 724 hospitals will have their payments reduced by 1 percent for discharges in FY 2015.
- Under the hospital VBP program, hospitals are scored based on both their performance and their improvement on quality and efficiency measures during a prior performance period. CMS is posting hospital VBP incentive payment adjustment factors for FY 2015 on the CMS website. For FY 2015, as required by law, the value-based incentive payments are funded by reducing the base operating DRG payment amounts by 1.5 percent, which results in approximately \$1.4 billion being available in the funding pool for incentive payments in FY 2015.

Two separate fact sheets are attached, and a blog by Dr. Patrick Conway, CMS Deputy Administrator for Innovation and Quality and Chief Medical Officer, can be read at the following link: <http://blog.cms.gov/>.

If you have any questions, please contact the CMS Office of Legislation. Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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FACT SHEET

FOR IMMEDIATE RELEASE
December 18, 2014

Contact: CMS Media Relations
(202) 690-6145 or press@cms.hhs.gov

Public reporting of 2013 quality measures on the Physician Compare and Hospital Compare Websites

Overview

The Centers for Medicare & Medicaid Services (CMS) has added new quality data to the Physician Compare website. Additionally, CMS has updated quality measures on the Hospital Compare website and released data on new measures. These websites are part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization and costs for effective, informed decision-making.

Physician Compare

The first quality measures were added to Physician Compare in February 2014. Since then, the number of groups reporting quality data through the Physician Quality Reporting System (PQRS) has doubled. Physician Compare is a website, authorized by the Affordable Care Act, to help consumers make informed choices about the health care they receive from Medicare physicians and other health care professionals. Publicly reporting this quality information on the Physician Compare website will help further that goal.

Public reporting of 2013 quality measures on the Physician Compare website

Today, CMS posted the publicly reported 2013 PQRS Group Practice Reporting Option (GPRO) measures for 139 group practices and 214 Shared Savings Program Accountable Care Organizations (ACOs) and 23 Pioneer ACOs. The specific measures being reported are:

- Controlling blood sugar levels in patients with diabetes (GPRO DM-15: Diabetes Mellitus: Hemoglobin A1c Control (<8%)).
- Controlling blood pressure in patients with diabetes (GPRO DM-13: Diabetes Mellitus: Blood Pressure Control in Patients with Diabetes).
- Prescribing aspirin to patients with diabetes and heart disease (GPRO DM-16: Diabetes Mellitus: Daily Aspirin Use for Patients with Diabetes and Ischemic Vascular Disease).
- Prescribing medicine to improve the pumping action of the heart in patients who have both heart disease and certain other conditions (GPRO CAD-7: Coronary Artery

Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)).

To make the information user-friendly for consumers, performance scores on each measure for the group practices are displayed on Physician Compare as stars followed by a percent, with each star representing 20 percent. The Physician Compare stars represent how each group practice performs on any given quality measure and provide a graphical way of looking at the data. The stars convey quality information, so more stars are better. If a group practice scores 80 percent on a measure, four fully-filled stars will be shown followed by “80%.” This indicates the practice performed very well in the category. The stars on Physician Compare are not used as a rating or ranking system because they do not serve to benchmark group practices against one another. You can visit an [example](#) group practice profile.

With this release in December 2014, CMS has now added four patient experience of care measures for ACOs. These are survey measures modeled on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for clinicians and group practices. These surveys ask patients about their experiences with their health care professionals. The surveys focus on matters that patients themselves say are important to them such as how well their doctors communicate and getting timely care, appointments, and information.

Currently, users have the ability to compare the general information for up to three group practices on Physician Compare. This includes names, addresses, distance from the search location, specialty, Medicare assignment, and affiliated health care professionals. However, users are not able to do side-by-side comparisons of measure data at this time. The ability to compare ACOs is also not available at this time. Consumers will have the ability to compare group practices and ACOs to one another in the future as more data are available.

Looking ahead, CMS plans to significantly expand the number of quality measures available for public reporting on Physician Compare. In late 2015, CMS will post quality measures for groups of all sizes and a subset of quality measures for individual physicians.

For a list of all of the group practices that currently have quality data, please view the Physician Compare [Downloadable Database](#).

For more information on Physician Compare, visit: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/>.

Hospital Compare

Hospital Compare provides information on hospital performance on a wide variety of quality measures, including how often the hospital provides recommended care, certain measures of healthcare infections, and how recently discharged patients responded to a national survey about their hospital experience. Public reporting of hospital performance information empowers consumers by providing information they can use to make more informed health care decisions, encourages providers to improve quality, and drives overall health system improvement.

Hospital Compare currently provides information on over 4,000 hospitals, updated on a quarterly basis. This includes measures from CMS' Hospital Inpatient and Outpatient Quality Reporting Programs and Hospital Value-Based Purchasing Program. The measures being reported for the first time are:

- Patient Experience of Care
 - Care transition survey measure
- Timely and Effective Care
 - Healthcare workers given influenza vaccination (Healthcare Provider Influenza Measure)
 - Heart surgery patients whose blood sugar (blood glucose) is kept under good control 18-24 hours after surgery (SCIP-Inf-4)
- Readmissions, Complications, & Deaths
 - 30-day risk-standardized mortality and readmission rates for COPD and stroke
- Payment and Value of Care
 - Payment for heart attack patients (AMI 30-day Episode of Care Payment)
- PPS-Exempt Cancer Hospital Quality Reporting Program
 - Adjuvant chemotherapy colon cancer
 - Combination chemotherapy breast cancer

The health care worker influenza measure was developed by the Centers for Disease Control and Prevention (CDC). This measure tracks the percentage of health care workers who have received the flu vaccine each flu season. It is recommended that all health care facilities provide the flu vaccine to their staff because doing so has been found to reduce the risk of flu illness, medical visits, antibiotic use, and flu-related deaths.

The Care Transition measure will also be reported for the first time today. The HCAHPS Survey is a standardized survey to measure patients' perspectives of their hospital care. The HCAHPS measures were created to publicly report patients' perspectives on their hospital care. The HCAHPS Care Transition Measure is a composite measure that captures how patients experience their care transition after their stay in an acute care setting. The Care Transition Measure reports how well patients understood the type of care they would need after leaving the hospital.

In addition to the new measures described above, the following new measures will be reported as part of Medicare hospital pay-for-performance programs:

- Hospital Value-Based Purchasing
 - Medicare Spending per Beneficiary (Efficiency domain)
 - Central line-associated bloodstream infection (CLABSI)
 - AHRQ PSI-90 composite measure
- Hospital Acquired Condition (HAC) Reduction Program
 - Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 composite measure

- Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) measure
- CDC NHSN Catheter-Associated Urinary Tract Infection (CAUTI) measure
- Hospital Readmission Reduction Program
 - Rate of complications for hip/knee replacement patients (30-day risk standardized readmission following elective, primary total hip and/or total knee replacement)
 - Rate of unplanned readmission for chronic obstructive pulmonary disease (COPD) patients (30-day risk standardized readmission for COPD)

For more information on Hospital Compare, please visit:
<http://www.medicare.gov/hospitalcompare/search.html>.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
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FACT SHEET

FOR IMMEDIATE RELEASE
December 18, 2014

Contact: CMS Media Relations
(202) 690-6145

Fiscal Year 2015 Results for the CMS Hospital-Acquired Condition Reduction Program and Hospital Value-Based Purchasing Program

Hospital-Acquired Condition (HAC) Reduction Program

Program Overview

The Hospital-Acquired Condition (HAC) Reduction Program is the newest effort under the Affordable Care Act that builds on the progress of reducing hospital acquired conditions achieved through the existing HAC program established under the Deficit Reduction Act (DRA) of 2005. The DRA HAC program currently saves the Medicare program approximately \$30 million annually. These savings are the result of not providing additional Medicare payment for treatment of certain reasonably preventable conditions when those conditions are acquired after the beneficiary has been admitted to the hospital.

The HAC Reduction Program uses public reporting and financial incentives to encourage Inpatient Prospective Payment System hospitals to reduce HACs and improve patient safety. The HACs, which are specified in rulemaking by the Centers for Medicare & Medicaid Services (CMS) each year, are a group of reasonably preventable conditions, including infections, that patients did not have upon admission to a hospital, but which developed during the hospital stay. The HAC Reduction Program builds on the Administration's efforts to achieve better patient outcomes while slowing health care cost growth.

Hospital performance under the HAC Reduction Program is determined based on a hospital's Total HAC Score, which can range from one to 10. The higher a hospital's Total HAC Score, the less well the hospital performed under the HAC Reduction Program. Effective beginning FY 2015, the law requires a payment reduction of one percent for all discharges for those hospitals that rank in the quartile of hospitals with the highest Total HAC Scores.

Fiscal Year 2015 Results

Results for the fiscal year (FY) 2015 HAC Reduction Program have been calculated and, pursuant to the law, hospitals have been given a chance to review their preliminary results and request a recalculation of their scores if they believe an error in score calculation has occurred.

Hospital specific HAC Reduction Program scores are being posted on the Hospital Compare website. In FY 2015, approximately 724 hospitals will have their payments reduced by one percent under the HAC Reduction Program. Payment for hospital discharges occurring on or after October, 1, 2014, are seeing a reduction.

Computing the Total HAC Score

The Total HAC Score is composed of two domains: patient safety (Domain 1) and healthcare-associated infections (Domain 2). For the FY 2015 HAC Reduction Program, Domain 1 included the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 composite measure, and Domain 2 included the Centers for Disease Control and Prevention National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) measures.

CMS based its decision on which measures to include in the HAC Reduction Program on currently available quality measures that are risk adjusted and reflective of hospital performance. Endorsement by the National Quality Forum (NQF) and support from the NQF-convened Measures Application Partnership (MAP) are also taken into account. NQF, a non-profit, nonpartisan, membership-based organization, uses a formal process for evaluating and endorsing quality measures. The MAP makes recommendations on measures most appropriate for public reporting, performance-based payment, and other uses across federal programs. The MAP includes representatives of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. Both the NQF endorsement and MAP recommendation processes involve public comment. All the measures finalized for inclusion in the HAC Reduction Program are NQF endorsed and were recommended for inclusion in the Program by the MAP. They were also included in the FY 2014 and 2015 proposed rules for additional public comments.

Moving Forward

CMS is currently evaluating several aspects of the HAC Reduction Program, including identification of new, potentially suitable measures to fill HAC performance gaps and examination of the scoring methodology to determine if modifications are needed. Public comments received during rulemaking have helped to inform this process of improving the HAC Reduction Program. In addition, CMS anticipates receiving additional valuable input during the MAP meetings in December 2014 and January 2015.

CMS' contractor, Yale/CORE, convened a Technical Expert Panel which is synthesizing input from a wide variety of experts with diverse perspectives on potential revisions to the scoring methodology and on potential new measures to propose for inclusion in the program. A summary of the Technical Expert Panel deliberations was made widely available in November, and stakeholders were given an opportunity for public comment.

Additional Information

Additional information about the HAC Reduction Program is available on Quality Net: <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166>

Hospital Value-Based Purchasing Program

Program Overview

The Hospital Value-Based Purchasing (VBP) Program, which is authorized by the Affordable Care Act, adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care they furnish to patients. For FY 2015, as directed by the law, the CMS increased the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, from 1.25 to 1.5 percent of the base operating DRG payment amounts to all participating hospitals. CMS estimates that the total amount available for value-based incentive payments in FY 2015 will be approximately \$1.4 billion.

The Hospital VBP Program provides a useful snapshot of how hospitals are performing on important quality indicators of patient care, quality, efficiency, and well-being and is one of many Affordable Care Act programs Medicare is implementing to pay for quality instead of quantity. The domains for FY 2015 were:

- Clinical Process of Care: 20 percent
- Patient Experience of Care (HCAHPS survey): 30 percent
- Outcome: (hospital mortality measures for acute myocardial infarction, heart failure, and pneumonia, and the central line-associated bloodstream infection measure): 30 percent
- Efficiency: (Medicare Spending per Beneficiary measure gauges efficiency by calculating total cost to Medicare for hospitals' episodes: 20 percent

The Hospital VBP Program is part of CMS' long-standing effort to structure Medicare's payment systems to improve healthcare quality, including the quality of care for hospital inpatients. The program is in its third year of value-based purchasing for the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,000 hospitals across the country. Hospitals are now paid for inpatient acute care services based on the *quality* of care, not just the *quantity* of the services they provide.

The program has been increasing the number of quality domains and measures it uses to evaluate performance, with the goal of including a broader, richer set of measures over time and aligning with the National Quality Strategy (NQS). CMS believes that the program's benefits will be seen in improved patient outcomes, safety, and in the patient's experience of care.

Fiscal Year 2015 Results

CMS has posted Hospital Value-Based Purchasing incentive payment adjustment factors for fiscal year 2015 on the CMS website. The Hospital VBP Program adjustment factors are available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html>.

Depending on how well hospitals measured up to their peers on important health-care quality measures during a prior performance period, and on how much they improved over their own

historical performance, they will be paid more or less for each Medicare fee-for-service discharge in fiscal year 2015 than they would have been paid in the absence of this program.

Hospitals excluded from the Hospital VBP Program in FY 2015 will not be included in the table containing the payment adjustment factors. Hospitals that are excluded from the Hospital Value-Based Purchasing Program do not incur the reduction of 1.5 percent and are not eligible to receive additional incentives.

Due to their desire to improve their quality of care, hospitals around the country are tracking their performance on Hospital Value-Based Purchasing measures via external performance dashboards that allow the continuous monitoring of their care provided and, in many cases, an estimated rate of incentive payment adjustment. This type of improvement focus should benefit patients.

The number of hospitals that will experience a positive change in their base operating diagnosis-related group (DRG) payments in fiscal year 2015 is slightly higher than the number of hospitals that will experience a negative change. In fiscal year 2015, about half of the hospitals see a small change in their base operating DRG payments (between -0.3 and 0.3 percent) – a reversal from last year.

Computing the VBP Score

The Hospital VBP Program is funded through a reduction from participating hospitals' base operating DRG payments for the applicable fiscal year. The payment reductions are redistributed to hospitals as incentive payments, based on their Total Performance Scores (TPS), as required by statute. The actual amount earned by each hospital will depend on its TPS, the hospital's value-based incentive payment percentage, and on the total amount available for value-based incentive payments. A hospital may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year. This means that the hospital could see an increase, a decrease, or no change to its Medicare payments for the applicable fiscal year.

The estimated amount of base operating DRG payment amount reductions for FY 2015 and the amount available for value-based incentive payments for FY 2015 discharges is approximately \$1.4 billion.

In FY 2015, hospitals' total performance scores were based on four domains: clinical process of care, patient experience of care, outcome, and a new efficiency domain.

Hospitals' TPSs were subject to minimum case and measure requirements and they had to have a domain score for at least two of the four domains, in order to have a TPS calculated. Hospitals that do not meet the minimum requirements do not have their payments adjusted in the corresponding fiscal year. For every measure, each of the hospitals participating in the Hospital Value-Based Purchasing Program receives the higher of its improvement score or its achievement score.

New Program Requirements

The FY 2017 measure set will add two new Safety measures and one new Clinical Care - Process measure, re-adopt the current version of the CLABSI measure, and remove six “topped-out” clinical process measures. Over 78 percent of the measures in the Hospital VBP Program will assess health outcomes, patient experience and cost.

CMS will adopt two new outcome measures for the new Safety domain: hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia and *Clostridium difficile* infection; and a Clinical Care - Process measure: early elective deliveries (PC-01).

FY 2017 Domain Weighting

CMS has finalized new quality domains based on the National Quality Strategy (NQS) and domain weighting for FY 2017. Due to the large number of “topped out” measures that CMS is removing from the FY 2017 measure set, the finalized FY 2017 domain weighting for hospitals that receive a score on all domains reduces the weight of the Clinical Care – Process subdomain to 5 percent and increases the weight of the Safety domain to 20 percent.

FY 2019/2020 Measure

CMS has adopted one new hospital-level risk-standardized complication rate following elective hip and knee arthroplasty measure with a 30-month performance period for FY 2019 and a 36-month performance period for FY 2020.

Moving Forward

As CMS moves forward with a regulatory framework that more closely links patient outcomes and treatment costs to value-based hospital payment, it's important to remember that the Hospital Value-Based Purchasing program not only aims for quality gains on paper, it also aims to promote the growth of a culture that is focused on the needs of patients.

Value-based purchasing in Medicare continues to move ahead, improving the way that health care is delivered to people with Medicare now and helping create a health care system that will ensure quality care for generations to come.

Additional Information

To see the FY 2015 value-based incentive payment adjustment factors, please visit:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/>.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 18 Dec 2014 14:44:28 -0500
To: Howell, Cherie A. (CMS/OL);DiSanto, Diane (Begich);Rep. Young;Sen. Begich;Sen. Murkowski;Rep. Womack;Rep. Cotton;Rep. cotton;Rep. Crawford;Rep. Crawford;Rep. Griffin;Sen. Boozman;Sen. Pryor;Rep. Alexander;Rep. Boustany;Rep. Boustany;Rep. Cassidy;Rep. Fleming;Rep. Richmond;Rep. Richmond;Rep. Scalise;Sen. Landrieu;Sen. Landrieu;Sen. Vitter;Rep. Labrador;Rep. Simpson;Sen. Crapo;Sen. Crapo;Sen. Risch (Rachel_burkett@risch.senate.gov);Rep. Lujan;Rep. Lujan;Rep. Lujan;Rep. Lujan (Jeffery.bustamante@mail.house.gov);Rep. Lujan Grisham;Rep. Pearce;Sen. Heinrich;Sen. Tom Udall;Gabe Sudduth;Pence, Laura (Coburn) (Laura_Pence@coburn.senate.gov);Rep. Bridenstine;Rep. Cole;Rep. Lankford;Rep. lankford;Rep. Lucas;Rep. Mullin (brittnee.preston@mail.house.gov);Sen. Inhofe;Rep. Blumenauer;Rep. Bonamici;Rep. Bonamici;Rep. DeFazio;Rep. DeFazio;Rep. Schrader;Rep. Walden;Rep. Blumenauer;Sen. Merkley (Susan_Lexer@merkley.senate.gov);Sen. Wyden;Rep. Burgess;Rep. AL Green;Rep. Barton;Rep. Brady;Rep. Burgess;Rep. Carter;Rep. Castro;Rep. Conaway;Rep. Cuellar;Rep. Cuellar;Rep. Culberson;Rep. Doggett;Rep. Eddie Bernice Johnson;Rep. Farenthold;Rep. Flores;Rep. Gallego;Rep. Gallego;Rep. Gallego;Rep. Gene Green;Rep. Gohmert;Rep. Granger;Rep. Hall;Rep. Hensarling;Rep. Hinojosa;Rep. Marchant;Rep. McCaul;Rep. Neugebauer;Rep. Olson;Rep. Orourke;Rep. O'Rourke;Rep. Poe;Rep. Sam Johnson;Rep. Sessions;Rep. Smith;Rep. Stockman;Rep. Thornberry;Rep. Veasey;Rep. Veasey;Rep. Veasey;Rep. Vela;Rep. Weber;Rep. Williams;Rep. Jackson Lee;Sen. Cornyn;Sen. Cornyn;Sen. Cruz;Rep. Adam Smith;Rep. DelBene;Rep. Hasting;Rep. Heck;Rep. Heck;Rep. Heck;Rep. Herrera;Rep. Kilmer;Rep. Kilmer;Rep. Larsen;Rep. McDermott;Rep. McMorris Rodgers;Rep. Reichert;Sen. Cantwell;Sen. Cantwell;Sen. Murray;Sen. Murray;Sen. Murray
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Physician Compare/Hospital Compare/HAC Data Posting/VBP Payment Adjustments
Attachments: Phys-Hosp Compare Fact Sheet 12-18-2014-FINAL.PDF, HACRP HVBP Public Reporting Fact Sheet 12 18 14-FINAL.PDF

U.S. House and Senate Notification

Thursday, December 18, 2014

To: Congressional Health Staff

From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Physician Compare/Hospital Compare/HAC Data Posting/VBP Payment Adjustments

The Centers for Medicare & Medicaid Services (CMS) today updated and added data on new quality measures to the Hospital Compare website and added new quality data to the Physician Compare website. In addition, CMS posted results online of the first year of the Hospital Acquired Condition (HAC) Reduction program and third year results under the hospital Value-Based Purchasing program. These data updates and releases include the following –

- Hospital Compare provides information on over 4,000 hospitals, and information is updated on a quarterly basis. Some of the measures being reported for the first time are: the Care Transition survey measure; the Healthcare Provider Influenza measure; the 30-day risk-standardized mortality and readmission rates for COPD and stroke; the 30 day episode of care payment measure for heart attack patients; and two measures under the for PPS-Exempt Cancer Hospital Quality Reporting program.
- The first quality measures were added to Physician Compare in February 2014. Today, CMS added to the website certain measures reported under the 2013 Physician Quality Reporting System Group Practice Reporting Option for 139 group practices, 214 Shared Savings Program Accountable Care Organizations (ACOs), and 23 Pioneer ACOs. The measures being reported include a subset of Diabetes measures and Coronary Artery Disease measures, and additionally for ACOs, four patient experience of care survey measures. As with the earlier posting of measures, this information is being displayed on Physician Compare using stars, and followed by a percentage score.
- The scores from the first year of the HAC Reduction program, which is required by section 3008 of the Affordable Care Act, are being posted online. This program requires that beginning in FY 2015, hospitals that rank in the top quartile with respect to hospital-acquired conditions will have their payment reduced by 1 percent for all discharges during the fiscal year. Hospital performance under the HAC Reduction Program is determined based on specified patient safety and healthcare-associated infection measures and a scoring methodology determined through notice and comment rulemaking. The results for FY 2015 were calculated under this program, and hospitals were given a chance to review their data and request a recalculation of their scores if they believed an error was made. Based on the total performance scores, approximately 724 hospitals will have their payments reduced by 1 percent for discharges in FY 2015.
- Under the hospital VBP program, hospitals are scored based on both their performance and their improvement on quality and efficiency measures during a prior performance period. CMS is posting hospital VBP incentive payment adjustment factors for FY 2015 on the CMS website. For FY 2015, as required by law, the value-based incentive payments are funded by reducing the base operating DRG payment amounts by 1.5 percent, which results in approximately \$1.4 billion being available in the funding pool for incentive payments in FY 2015.

Two separate fact sheets are attached, and a blog by Dr. Patrick Conway, CMS Deputy Administrator for Innovation and Quality and Chief Medical Officer, can be read at the following link: <http://blog.cms.gov/>.

If you have any questions, please contact the CMS Office of Legislation. Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201



FACT SHEET

FOR IMMEDIATE RELEASE
December 18, 2014

Contact: CMS Media Relations
(202) 690-6145 or press@cms.hhs.gov

Public reporting of 2013 quality measures on the Physician Compare and Hospital Compare Websites

Overview

The Centers for Medicare & Medicaid Services (CMS) has added new quality data to the Physician Compare website. Additionally, CMS has updated quality measures on the Hospital Compare website and released data on new measures. These websites are part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization and costs for effective, informed decision-making.

Physician Compare

The first quality measures were added to Physician Compare in February 2014. Since then, the number of groups reporting quality data through the Physician Quality Reporting System (PQRS) has doubled. Physician Compare is a website, authorized by the Affordable Care Act, to help consumers make informed choices about the health care they receive from Medicare physicians and other health care professionals. Publicly reporting this quality information on the Physician Compare website will help further that goal.

Public reporting of 2013 quality measures on the Physician Compare website

Today, CMS posted the publicly reported 2013 PQRS Group Practice Reporting Option (GPRO) measures for 139 group practices and 214 Shared Savings Program Accountable Care Organizations (ACOs) and 23 Pioneer ACOs. The specific measures being reported are:

- Controlling blood sugar levels in patients with diabetes (GPRO DM-15: Diabetes Mellitus: Hemoglobin A1c Control (<8%)).
- Controlling blood pressure in patients with diabetes (GPRO DM-13: Diabetes Mellitus: Blood Pressure Control in Patients with Diabetes).
- Prescribing aspirin to patients with diabetes and heart disease (GPRO DM-16: Diabetes Mellitus: Daily Aspirin Use for Patients with Diabetes and Ischemic Vascular Disease).
- Prescribing medicine to improve the pumping action of the heart in patients who have both heart disease and certain other conditions (GPRO CAD-7: Coronary Artery

Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)).

To make the information user-friendly for consumers, performance scores on each measure for the group practices are displayed on Physician Compare as stars followed by a percent, with each star representing 20 percent. The Physician Compare stars represent how each group practice performs on any given quality measure and provide a graphical way of looking at the data. The stars convey quality information, so more stars are better. If a group practice scores 80 percent on a measure, four fully-filled stars will be shown followed by “80%.” This indicates the practice performed very well in the category. The stars on Physician Compare are not used as a rating or ranking system because they do not serve to benchmark group practices against one another. You can visit an [example](#) group practice profile.

With this release in December 2014, CMS has now added four patient experience of care measures for ACOs. These are survey measures modeled on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for clinicians and group practices. These surveys ask patients about their experiences with their health care professionals. The surveys focus on matters that patients themselves say are important to them such as how well their doctors communicate and getting timely care, appointments, and information.

Currently, users have the ability to compare the general information for up to three group practices on Physician Compare. This includes names, addresses, distance from the search location, specialty, Medicare assignment, and affiliated health care professionals. However, users are not able to do side-by-side comparisons of measure data at this time. The ability to compare ACOs is also not available at this time. Consumers will have the ability to compare group practices and ACOs to one another in the future as more data are available.

Looking ahead, CMS plans to significantly expand the number of quality measures available for public reporting on Physician Compare. In late 2015, CMS will post quality measures for groups of all sizes and a subset of quality measures for individual physicians.

For a list of all of the group practices that currently have quality data, please view the Physician Compare [Downloadable Database](#).

For more information on Physician Compare, visit: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/>.

Hospital Compare

Hospital Compare provides information on hospital performance on a wide variety of quality measures, including how often the hospital provides recommended care, certain measures of healthcare infections, and how recently discharged patients responded to a national survey about their hospital experience. Public reporting of hospital performance information empowers consumers by providing information they can use to make more informed health care decisions, encourages providers to improve quality, and drives overall health system improvement.

Hospital Compare currently provides information on over 4,000 hospitals, updated on a quarterly basis. This includes measures from CMS' Hospital Inpatient and Outpatient Quality Reporting Programs and Hospital Value-Based Purchasing Program. The measures being reported for the first time are:

- Patient Experience of Care
 - Care transition survey measure
- Timely and Effective Care
 - Healthcare workers given influenza vaccination (Healthcare Provider Influenza Measure)
 - Heart surgery patients whose blood sugar (blood glucose) is kept under good control 18-24 hours after surgery (SCIP-Inf-4)
- Readmissions, Complications, & Deaths
 - 30-day risk-standardized mortality and readmission rates for COPD and stroke
- Payment and Value of Care
 - Payment for heart attack patients (AMI 30-day Episode of Care Payment)
- PPS-Exempt Cancer Hospital Quality Reporting Program
 - Adjuvant chemotherapy colon cancer
 - Combination chemotherapy breast cancer

The health care worker influenza measure was developed by the Centers for Disease Control and Prevention (CDC). This measure tracks the percentage of health care workers who have received the flu vaccine each flu season. It is recommended that all health care facilities provide the flu vaccine to their staff because doing so has been found to reduce the risk of flu illness, medical visits, antibiotic use, and flu-related deaths.

The Care Transition measure will also be reported for the first time today. The HCAHPS Survey is a standardized survey to measure patients' perspectives of their hospital care. The HCAHPS measures were created to publicly report patients' perspectives on their hospital care. The HCAHPS Care Transition Measure is a composite measure that captures how patients experience their care transition after their stay in an acute care setting. The Care Transition Measure reports how well patients understood the type of care they would need after leaving the hospital.

In addition to the new measures described above, the following new measures will be reported as part of Medicare hospital pay-for-performance programs:

- Hospital Value-Based Purchasing
 - Medicare Spending per Beneficiary (Efficiency domain)
 - Central line-associated bloodstream infection (CLABSI)
 - AHRQ PSI-90 composite measure
- Hospital Acquired Condition (HAC) Reduction Program
 - Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 composite measure

- Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) measure
- CDC NHSN Catheter-Associated Urinary Tract Infection (CAUTI) measure
- Hospital Readmission Reduction Program
 - Rate of complications for hip/knee replacement patients (30-day risk standardized readmission following elective, primary total hip and/or total knee replacement)
 - Rate of unplanned readmission for chronic obstructive pulmonary disease (COPD) patients (30-day risk standardized readmission for COPD)

For more information on Hospital Compare, please visit:
<http://www.medicare.gov/hospitalcompare/search.html>.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
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200 Independence Avenue, SW
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FACT SHEET

FOR IMMEDIATE RELEASE
December 18, 2014

Contact: CMS Media Relations
(202) 690-6145

Fiscal Year 2015 Results for the CMS Hospital-Acquired Condition Reduction Program and Hospital Value-Based Purchasing Program

Hospital-Acquired Condition (HAC) Reduction Program

Program Overview

The Hospital-Acquired Condition (HAC) Reduction Program is the newest effort under the Affordable Care Act that builds on the progress of reducing hospital acquired conditions achieved through the existing HAC program established under the Deficit Reduction Act (DRA) of 2005. The DRA HAC program currently saves the Medicare program approximately \$30 million annually. These savings are the result of not providing additional Medicare payment for treatment of certain reasonably preventable conditions when those conditions are acquired after the beneficiary has been admitted to the hospital.

The HAC Reduction Program uses public reporting and financial incentives to encourage Inpatient Prospective Payment System hospitals to reduce HACs and improve patient safety. The HACs, which are specified in rulemaking by the Centers for Medicare & Medicaid Services (CMS) each year, are a group of reasonably preventable conditions, including infections, that patients did not have upon admission to a hospital, but which developed during the hospital stay. The HAC Reduction Program builds on the Administration's efforts to achieve better patient outcomes while slowing health care cost growth.

Hospital performance under the HAC Reduction Program is determined based on a hospital's Total HAC Score, which can range from one to 10. The higher a hospital's Total HAC Score, the less well the hospital performed under the HAC Reduction Program. Effective beginning FY 2015, the law requires a payment reduction of one percent for all discharges for those hospitals that rank in the quartile of hospitals with the highest Total HAC Scores.

Fiscal Year 2015 Results

Results for the fiscal year (FY) 2015 HAC Reduction Program have been calculated and, pursuant to the law, hospitals have been given a chance to review their preliminary results and request a recalculation of their scores if they believe an error in score calculation has occurred.

Hospital specific HAC Reduction Program scores are being posted on the Hospital Compare website. In FY 2015, approximately 724 hospitals will have their payments reduced by one percent under the HAC Reduction Program. Payment for hospital discharges occurring on or after October, 1, 2014, are seeing a reduction.

Computing the Total HAC Score

The Total HAC Score is composed of two domains: patient safety (Domain 1) and healthcare-associated infections (Domain 2). For the FY 2015 HAC Reduction Program, Domain 1 included the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 composite measure, and Domain 2 included the Centers for Disease Control and Prevention National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) measures.

CMS based its decision on which measures to include in the HAC Reduction Program on currently available quality measures that are risk adjusted and reflective of hospital performance. Endorsement by the National Quality Forum (NQF) and support from the NQF-convened Measures Application Partnership (MAP) are also taken into account. NQF, a non-profit, nonpartisan, membership-based organization, uses a formal process for evaluating and endorsing quality measures. The MAP makes recommendations on measures most appropriate for public reporting, performance-based payment, and other uses across federal programs. The MAP includes representatives of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. Both the NQF endorsement and MAP recommendation processes involve public comment. All the measures finalized for inclusion in the HAC Reduction Program are NQF endorsed and were recommended for inclusion in the Program by the MAP. They were also included in the FY 2014 and 2015 proposed rules for additional public comments.

Moving Forward

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CMS' contractor, Yale/CORE, convened a Technical Expert Panel which is synthesizing input from a wide variety of experts with diverse perspectives on potential revisions to the scoring methodology and on potential new measures to propose for inclusion in the program. A summary of the Technical Expert Panel deliberations was made widely available in November, and stakeholders were given an opportunity for public comment.

Additional Information

Additional information about the HAC Reduction Program is available on Quality Net: <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166>

Hospital Value-Based Purchasing Program

Program Overview

The Hospital Value-Based Purchasing (VBP) Program, which is authorized by the Affordable Care Act, adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care they furnish to patients. For FY 2015, as directed by the law, the CMS increased the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, from 1.25 to 1.5 percent of the base operating DRG payment amounts to all participating hospitals. CMS estimates that the total amount available for value-based incentive payments in FY 2015 will be approximately \$1.4 billion.

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- Clinical Process of Care: 20 percent
- Patient Experience of Care (HCAHPS survey): 30 percent
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- Efficiency: (Medicare Spending per Beneficiary measure gauges efficiency by calculating total cost to Medicare for hospitals' episodes: 20 percent

The Hospital VBP Program is part of CMS' long-standing effort to structure Medicare's payment systems to improve healthcare quality, including the quality of care for hospital inpatients. The program is in its third year of value-based purchasing for the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,000 hospitals across the country. Hospitals are now paid for inpatient acute care services based on the *quality* of care, not just the *quantity* of the services they provide.

The program has been increasing the number of quality domains and measures it uses to evaluate performance, with the goal of including a broader, richer set of measures over time and aligning with the National Quality Strategy (NQS). CMS believes that the program's benefits will be seen in improved patient outcomes, safety, and in the patient's experience of care.

Fiscal Year 2015 Results

CMS has posted Hospital Value-Based Purchasing incentive payment adjustment factors for fiscal year 2015 on the CMS website. The Hospital VBP Program adjustment factors are available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html>.

Depending on how well hospitals measured up to their peers on important health-care quality measures during a prior performance period, and on how much they improved over their own

historical performance, they will be paid more or less for each Medicare fee-for-service discharge in fiscal year 2015 than they would have been paid in the absence of this program.

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Due to their desire to improve their quality of care, hospitals around the country are tracking their performance on Hospital Value-Based Purchasing measures via external performance dashboards that allow the continuous monitoring of their care provided and, in many cases, an estimated rate of incentive payment adjustment. This type of improvement focus should benefit patients.

The number of hospitals that will experience a positive change in their base operating diagnosis-related group (DRG) payments in fiscal year 2015 is slightly higher than the number of hospitals that will experience a negative change. In fiscal year 2015, about half of the hospitals see a small change in their base operating DRG payments (between -0.3 and 0.3 percent) – a reversal from last year.

Computing the VBP Score

The Hospital VBP Program is funded through a reduction from participating hospitals' base operating DRG payments for the applicable fiscal year. The payment reductions are redistributed to hospitals as incentive payments, based on their Total Performance Scores (TPS), as required by statute. The actual amount earned by each hospital will depend on its TPS, the hospital's value-based incentive payment percentage, and on the total amount available for value-based incentive payments. A hospital may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year. This means that the hospital could see an increase, a decrease, or no change to its Medicare payments for the applicable fiscal year.

The estimated amount of base operating DRG payment amount reductions for FY 2015 and the amount available for value-based incentive payments for FY 2015 discharges is approximately \$1.4 billion.

In FY 2015, hospitals' total performance scores were based on four domains: clinical process of care, patient experience of care, outcome, and a new efficiency domain.

Hospitals' TPSs were subject to minimum case and measure requirements and they had to have a domain score for at least two of the four domains, in order to have a TPS calculated. Hospitals that do not meet the minimum requirements do not have their payments adjusted in the corresponding fiscal year. For every measure, each of the hospitals participating in the Hospital Value-Based Purchasing Program receives the higher of its improvement score or its achievement score.

New Program Requirements

The FY 2017 measure set will add two new Safety measures and one new Clinical Care - Process measure, re-adopt the current version of the CLABSI measure, and remove six “topped-out” clinical process measures. Over 78 percent of the measures in the Hospital VBP Program will assess health outcomes, patient experience and cost.

CMS will adopt two new outcome measures for the new Safety domain: hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia and *Clostridium difficile* infection; and a Clinical Care - Process measure: early elective deliveries (PC-01).

FY 2017 Domain Weighting

CMS has finalized new quality domains based on the National Quality Strategy (NQS) and domain weighting for FY 2017. Due to the large number of “topped out” measures that CMS is removing from the FY 2017 measure set, the finalized FY 2017 domain weighting for hospitals that receive a score on all domains reduces the weight of the Clinical Care – Process subdomain to 5 percent and increases the weight of the Safety domain to 20 percent.

FY 2019/2020 Measure

CMS has adopted one new hospital-level risk-standardized complication rate following elective hip and knee arthroplasty measure with a 30-month performance period for FY 2019 and a 36-month performance period for FY 2020.

Moving Forward

As CMS moves forward with a regulatory framework that more closely links patient outcomes and treatment costs to value-based hospital payment, it's important to remember that the Hospital Value-Based Purchasing program not only aims for quality gains on paper, it also aims to promote the growth of a culture that is focused on the needs of patients.

Value-based purchasing in Medicare continues to move ahead, improving the way that health care is delivered to people with Medicare now and helping create a health care system that will ensure quality care for generations to come.

Additional Information

To see the FY 2015 value-based incentive payment adjustment factors, please visit:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/>.

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Cc: Phillips, Josh A. (CMS/OL);Lewandowski, David S. (CMS/OL);Saklas, Ariadne (CMS/OL)
Subject: Hill Notification: Registration for Electronic Health Records Incentives Starts January 3, 2011

**U.S. House and Senate Notification
December 23, 2010**

To: Congressional Health Staff

**From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: Registration for Electronic Health Records Incentives Starts January 3, 2011

Yesterday, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced the availability of registration for the Medicare and Medicaid electronic health record (EHR) incentive programs. Eligible health care professionals and eligible hospitals must register in order to participate in the incentive programs.

Beginning January 3, 2011, registration will be available for eligible professionals and eligible hospitals who wish to participate in the Medicare EHR incentive program. On the same date, registration in the Medicaid EHR Incentive Program will also be available in Alaska, Iowa, Kentucky, Louisiana, Oklahoma, Michigan, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. In February, registration will open in California, Missouri, and North Dakota. Other states will likely launch their Medicaid EHR Incentive Programs during the spring and summer of 2011.

The CMS and ONC encourage broad participation and outline online and in-person resources that are in place to assist eligible professionals and eligible hospitals who wish to participate. For more information please read the CMS press release at:

<https://www.cms.gov/apps/media/press/release.asp?Counter=3887&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

If you have any questions about this announcement, please contact the CMS Office of Legislation at 202-690-8220.

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Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: Report to Congress on Medicaid National Correct Coding Initiative

Attachments: RTC Mandatory State Use of National Correct Coding Initiative.pdf

**U.S. House and Senate Notification
March 2, 2011**

To: Congressional Health Staff

**From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: Report to Congress on Medicaid National Correct Coding Initiative (NCCI)

Yesterday, the Department of Health and Human Services submitted the attached Report to Congress entitled, "Implementation of the National Correct Coding Initiative in the Medicaid Program." This report is being submitted to Congress in response to a requirement in section 6507 of the Affordable Care Act. This section amends section 1903(r) of the Social Security Act to require the Secretary to submit to Congress by March 1, 2011, a report on implementation of the National Correct Coding Initiative (NCCI) in the Medicaid program. This report fulfills that requirement and highlights progress made on implementation.

The NCCI is a Centers for Medicare & Medicaid Services (CMS) program that consists of coding policies and edits. This program was originally implemented in the Medicare program in January 1996 to ensure accurate coding and reporting of services by physicians. Section 1903(r) of the Social Security Act, as amended by the Affordable Care Act, requires States to incorporate compatible methodologies of the NCCI, and such other methodologies that the Secretary identifies, for Medicaid claims filed on or after October 1, 2010. CMS issued guidance to States on implementation of the NCCI in Medicaid through a State Medicaid Director Letter dated September 1, 2010. This guidance can be found in Appendix A of the attached Report to Congress.

Please contact the CMS Office of Legislation with any questions 202-690-8220.



U.S. Department of Health and Human Services

**REPORT TO CONGRESS ON
IMPLEMENTATION OF THE NATIONAL CORRECT
CODING INITIATIVE IN THE MEDICAID PROGRAM**

**Kathleen Sebelius
Secretary of Health and Human Services
2011**

REPORT TO CONGRESS ON IMPLEMENTATION OF THE NATIONAL
CORRECT CODING INITIATIVE (NCCI) IN THE MEDICAID PROGRAM
AS REQUIRED BY SECTION 6507 OF THE AFFORDABLE CARE ACT

2.25.11[3]

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INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

EXECUTIVE SUMMARY

The National Correct Coding Initiative (NCCI) is a program of the Centers for Medicare & Medicaid Services (CMS) that consists of coding policies and edits. This program was originally implemented in the Medicare program in January 1996 to ensure accurate coding and reporting of services by physicians. Section 6507 of the Affordable Care Act requires CMS to notify States which NCCI methodologies are compatible with claims filed with Medicaid and requires States to use these methodologies to process claims filed on or after October 1, 2010.

The CMS met the statute's requirements through the issuance of a State Medicaid Director Letter on September 1, 2010, which notified the States that the five Medicare NCCI methodologies are compatible with the Medicaid program and how the States are to incorporate these methodologies for processing Medicaid claims. CMS also provided the States on September 1, 2010, with the Medicaid NCCI files for processing Medicaid claims filed on or after October 1, 2010. CMS provided States with the flexibility to deactivate NCCI edits and Medically Unlikely Edits (MUEs) until March 31, 2011, under certain circumstances. This Report to Congress fulfills the statutory requirement for a report to be submitted to Congress by March 1, 2011, and also highlights progress made on implementation.

Each of these NCCI methodologies has four components: the edits, definitions of the types of claims subject to the edits, claims adjudication rules for applying the edits, and rules for provider appeals of denials of payment for claims due to the edits.¹ The five NCCI edit files consist of (1) NCCI procedure-to-procedure edits for practitioner and ambulatory surgery center (ASC) services, (2) NCCI procedure-to-procedure edits for outpatient hospital services, (3) units-of-service MUEs for practitioner and ASC services, (4) units-of-service MUEs for outpatient hospital services, and (5) units-of-service MUEs for durable medical equipment (DME). CMS used the expertise and analysis of its NCCI technical contractor, Correct Coding Solutions, LLC, to determine that all five of the NCCI methodologies are compatible with the Medicaid program.

For most States, implementing the NCCI methodologies in their Medicaid programs by the statutory deadline has been a significant challenge both technically and financially. Some States lack familiarity with the NCCI methodologies, have outdated systems for processing Medicaid claims that are unable to download the Medicaid NCCI files without changes, rely on commercial off-the-shelf (COTS) products to implement the methodologies, and / or lack the required process for providers to appeal denials of Medicaid claims due to the NCCI methodologies.

Through the Advance Planning Document (APD) process, States are to request CMS approval for enhanced Federal financial participation (FFP) to implement the Medicaid NCCI methodologies and to deactivate NCCI edits and MUEs after March 31, 2011, and to report data on multiple measures of NCCI implementation. Few States have submitted APDs to CMS for these purposes at this time.

¹ Based on feedback from States, CMS has recently revised its finding on an appeals process. CMS now finds that the requirement for an appeals process is incompatible with Medicaid. Please see section 3.2 of the Report.

The CMS has worked closely with State Medicaid programs, both in groups and individually, to implement the NCCI methodologies. Fully and correctly implementing the NCCI methodologies in State Medicaid programs will be a long-term, resource-intensive undertaking by both CMS and the States. However, it is expected to result in significant savings in program expenditures due to reductions in inappropriate payments for Medicaid claims with improper coding, as has occurred in the Medicare program.

1.0 SECTION 6507 OF THE AFFORDABLE CARE ACT

The Centers for Medicare & Medicaid Services (CMS) submits this Report to Congress in fulfillment of one of the requirements contained in section 6507, “Mandatory State Use of National Correct Coding Initiative (NCCI)”, of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), which together are referred to as the “Affordable Care Act.”

This section amends section 1903(r) of the Social Security Act (the Act). Section 1903(r)(4) of the Act, as amended, required CMS to take three specific actions by September 1, 2010:

- identify and notify States of NCCI methodologies that are “compatible” with claims filed with Medicaid to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid;
- notify States of the NCCI methodologies (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) that should be incorporated for claims filed with Medicaid for which no national correct coding methodology has been established for Medicare; and
- inform States as to how they must incorporate these methodologies for claims filed under Medicaid.

Section 1903(r)(1)(B)(iv) of the Act, as amended, requires that States incorporate compatible methodologies of the NCCI administered by the Secretary and such other methodologies as the Secretary identifies, effective for Medicaid claims filed on or after October 1, 2010.

By March 1, 2011, CMS must submit a report to Congress that includes the September 1, 2010, notice to States and an analysis supporting these methodologies.

2.0 IMPLEMENTATION BY CMS

2.1 Process of How Determinations were Made

The NCCI is a CMS program that consists of coding policies and edits. This program was originally implemented to ensure accurate coding and reporting of services by physicians. The

NCCI methodologies have been successfully used by the Medicare program since the mid-1990s and have been proven to save Medicare millions of dollars in program expenditures.²

The CMS technical contractor for the NCCI for both Medicare and Medicaid, Correct Coding Solutions (CCS), LLC, utilizing its technical knowledge of the NCCI methodologies and of the Medicaid program, examined and analyzed the NCCI methodologies to determine if any of the NCCI methodologies are incompatible with the Medicaid program. CCS, LLC's technical analysis included reviewing the broader methodologies and confirming their consistency with Medicaid's program structure.

Based upon Medicare's success with the NCCI methodologies and the technical examination and analysis of the NCCI methodologies conducted by CCS, LLC, CMS determined that all of the NCCI methodologies are compatible with Medicaid.

Given CMS' determination that all of the NCCI methodologies are compatible with Medicaid, CMS determined that all of the NCCI methodologies should be adopted by State Medicaid programs.

While CMS has determined that all of the NCCI methodologies are compatible with the Medicaid program, not all of the edits in Medicare's NCCI methodologies are compatible with the Medicaid program. NCCI edits and Medically Unlikely Edits (MUEs) are one of four components of the NCCI methodologies. CCS, LLC, has begun identifying which edits are not compatible with the Medicaid program and has removed these edits from the Medicaid NCCI files for State Medicaid programs. State Medicaid programs and their fiscal agents, contractors, and providers may identify other NCCI edits which are not compatible with Medicaid. Identifying edits in the NCCI methodologies which are not compatible with the Medicaid program, and removing them from the Medicaid NCCI files for State Medicaid programs, will be a continuous process throughout the life of the NCCI.

As required by section 1903(r)(4) of the Act, CMS identified NCCI methodologies not utilized by the Medicare NCCI that are compatible with the State Medicaid programs. These methodologies follow:

- (1) The Medicare program does not apply NCCI procedure-to-procedure edits to outpatient services in critical access hospitals. CMS decided to require that State Medicaid programs apply them to these types of outpatient services. CMS plans to explore expanding the Medicaid NCCI methodologies to other Medicaid services that are not currently adjudicated against these edits. For example, the NCCI methodology units-of-service MUEs utilized for outpatient hospital services may be expanded to cover other types of facility services, such as nursing homes and renal dialysis facilities.

² Use of the NCCI procedure-to-procedure edits for practitioner and ambulatory surgery center services saved the Medicare program \$485.8 million in FY 2010. The NCCI methodology procedure-to-procedure edits applied to practitioner and ambulatory surgery center services have prevented the inappropriate payment by Medicare of over \$5 billion since 1996 based on savings reports from claims processing contractors. There are no savings reports on the other four Medicare NCCI methodologies, but there is anecdotal evidence that the savings are substantial.

- (2) The Medicare program requires the use of the NCCI methodologies by claims processing contractors adjudicating fee-for-service claims. In addition to mandating use of NCCI methodologies by State systems for processing Medicaid fee-for-service claims, CMS allows Medicaid managed care plans in a State to use the Medicaid NCCI methodologies as well, if the State Medicaid program allows such plans to do so.

Prior to September 1, 2010, very few States had experience with all five of the Medicaid NCCI methodologies. Implementing them requires developing new claims processing logic, integrating the processing logic into claims processing software, testing the logic, educating claims processing contractor staff, and educating the provider community. Since most of the provider community is familiar with Medicare NCCI methodologies, as are the State Medicaid programs which previously used one or more of Medicare's NCCI methodologies, CMS decided to allow States to initially implement those Medicare NCCI methodologies compatible with State Medicaid programs and to implement the NCCI methodologies not utilized by Medicare at a later date.

2.2 Description of the Medicaid NCCI Methodologies³

Each of the NCCI methodologies consists of the following four components:

- (1) a set of edits;
- (2) definitions of types of claims subject to the edits;
- (3) a set of claims adjudication rules for applying the edits; and
- (4) a set of rules for addressing provider appeals of denied payments for services based on the edits.⁴

The NCCI edits are defined as edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits:

- (1) NCCI edits, or procedure-to-procedure edits, that define pairs of Healthcare Common Procedure Coding System (HCPCS) and / or Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons and
- (2) Medically Unlikely Edits (MUEs), or units-of-service edits, that define for each HCPCS / CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g., claims for excision of more than one gallbladder).

³ The Medicaid NCCI methodologies do not incorporate Medicare units-of-service Medically Unlikely Edits (MUEs) that are confidential. Although most Medicare and all Medicaid MUEs are published on the CMS Web site, the Medicare program does not publish many MUE values that are greater than three in an effort to guard against fraud and abuse.

⁴ Based on feedback from States, CMS has recently revised its finding on an appeals process. CMS now finds that the requirement for an appeals process is incompatible with Medicaid. Please see section 3.2 of the Report.

The NCCI consists of five methodologies in both the Medicare and the Medicaid programs:

- (1) NCCI procedure-to-procedure edits for practitioner and ambulatory surgical center (ASC) services
- (2) NCCI procedure-to-procedure edits for outpatient hospital services⁵
- (3) MUE units-of-service edits for practitioner and ASC services
- (4) MUE units-of-service edits for outpatient hospital services for hospitals
- (5) MUE units-of-service edits for durable medical equipment.

2.3 Documents Issued to States

2.3.1 State Medicaid Director Letter

On September 1, 2010, CMS issued State Medicaid Director (SMD) Letter 10-017, "Implementation of NCCI in State Medicaid Programs," to fulfill the requirements in section 1903(r)(4) of the Act. The letter provides guidance to States on the definition of the NCCI methodologies and the implementation of the methodologies.

The CMS required that States implement all five NCCI methodologies for Medicaid claims filed on or after October 1, 2010. However, CMS provided flexibility to States to deactivate NCCI edits and MUEs, under certain circumstances, until March 31, 2011. After March 31, 2011, States will only be able to deactivate NCCI edits and MUEs with prior CMS approval through the Advance Planning Document (APD) process. CMS will approve such deactivation only if the State can document that the edits conflict with State law, regulation, administrative rule, or payment policy.

A copy of this SMD Letter is contained in Appendix A. Section 1903(r)(4) of the Act requires that this September 1, 2010, notice to States be included in this Report to Congress.

2.3.2 Advance Planning Document (APD) Template

The CMS has provided an APD template to States for implementation of the NCCI in their Medicaid programs. Below is an overview of the uses outlined in the APD.

⁵ Due to program payment and policy differences, these edits are applied differently in Medicaid than they are in Medicare. In Medicare, NCCI procedure-to-procedure edits for outpatient hospital services (including emergency department, observation, and hospital laboratory services) are incorporated into the outpatient code editor (OCE) for hospitals reimbursed through the hospital outpatient prospective payment system (OPPS). These same edits in the OCE are applied to certain types of bills, which pick up almost all facility therapy services billed with CPT codes to the Medicare Fiscal Intermediary (Part A Hospital / Part B Practitioner Medicare Administrative Contractors (A/B MACs) processing claims with the Fiscal Intermediary Shared System (FISS)). They do not apply to hospitals not reimbursed through the OPPS (e.g., Critical Access Hospitals (CAHs)). In Medicaid, these edits are applied to claims from CAHs.

- Part I is to be used by States to request CMS approval for enhanced Federal financial participation (FFP) to implement the NCCI in their systems for processing Medicaid claims (i.e., their Medicaid Management Information Systems (MMISs)).⁶
- Part II is to be used by States to request CMS approval to deactivate NCCI edits and MUEs in the Medicaid NCCI files after March 31, 2011, because they conflict with State law, regulation, administrative rule, or payment policy.
- Part III is to be used by States to report certain information to CMS regarding implementation of the NCCI in their MMISs. CMS has requested that the States provide information on the following:
 - State reimbursement of Medicaid claims that is not based on HCPCS) and / or CPT codes (for which the Medicaid NCCI methodologies do not apply);
 - savings in payments for Medicaid claims due to the State's implementation of the NCCI methodologies in its MMIS;
 - NCCI edits and MUEs deactivated by the State during the period October 1, 2010, through January 31, 2011; and
 - correct coding methodologies and edits used by States in addition to the NCCI methodologies.

The above information is explained in more detail in a copy of this APD template that is contained in Appendix B.

2.4 Web Sites

2.4.1 CMS Medicaid Integrity Institute

To support the ongoing administration of a national Medicaid NCCI program as required under section 1903(r)(4) of the Act, CMS has developed a standard process to manage and publish the NCCI methodology files to ensure that timely, accurate, and current edit files are available to all States. This process was communicated to States in SMD Letter 10-017 (Appendix A).

Five different edit files, consisting of Practitioner and ASC NCCI edits, Hospital Outpatient NCCI edits, Practitioner MUEs, Durable Medical Equipment MUEs, and Hospital Outpatient MUEs, were developed and provided to States as Version 1.3.1, effective October 1, 2010, of the

⁶ Section 1903(r) of the Act requires State MMISs to include Medicaid NCCI methodologies as part of their functionality. Section 1903(a)(3) of the Act provides CMS with the authority to provide 90-percent FFP to States for design, development, installation, and enhancement activities and 75-percent FFP for maintenance and operations of a certified State's MMIS system and for the cost of licensing proprietary products. Thus, in considering revisions to a State's MMIS, CMS is authorized to provide FFP to States to incorporate Medicaid NCCI methodologies into the State's MMIS system.

Medicaid NCCI methodology files. Updated versions are provided to States approximately 15 days prior to the beginning of each calendar quarter.

On September 1, 2010, CMS made available to States the five different Medicaid NCCI methodology edit files (referred to as MCDNCCI) on the secure Medicaid Integrity Institute (MII) WorkSpace Web site for review and use by States for Medicaid claims filed on or after October 1, 2010. Each State currently has at least one user license to access the site. CMS reviewed and tested the Web site to create folders with access restricted to licensed users to further protect and maintain the integrity of the edit files. On December 15, 2010, updated edit files, entitled Version 2.0, effective January 1, 2011, were posted to the MII WorkSpace Web site. These files are the most current national edit files for States to utilize. CMS plans to continue to provide States with Medicaid NCCI files updated for each calendar quarter using this Web site.

Medicare provides its NCCI files to its administrative contractors in only one file format (ASCII.TXT), but these files are available to others in three file formats: ASCII.TXT, Excel 2007 (.xlsx), and tab-delimited text (.txt) with column headings. Medicaid provides its NCCI files to States in the same three file formats.

2.4.2 CMS Web Site

The CMS created a subwebsite on CMS' main Web site to make information on implementation of the NCCI in Medicaid and the quarterly Medicaid NCCI files publicly available, as Medicare does. The subwebsite is located at <http://www.cms.gov/MedicaidNCCICoding/>. In support of the NCCI program, CMS posts publicly viewable edit files, reference materials, and guidance on this Web site at the beginning of each calendar quarter.⁷ CMS posted the publicly viewable first quarterly Medicaid NCCI edit files for October – December 2010 on this subwebsite on October 1, 2010. The second quarterly Medicaid NCCI files for January – March 2011 were posted on the subwebsite in early January 2011.

⁷ The CMS provides the following resources on this Web site:

- (1) Medicaid NCCI Methodology Files for State Medicaid Agencies and Fiscal Agents to Download
- (2) Medicaid NCCI Methodology Files on CMS Website
- (3) Medicaid NCCI and MUE Claims Processing Rules, File Names and Formats, Characteristics of Edits, Use of CLEID, and Appeal Adjudication
- (4) MCDNCCI Appeals Process
- (5) Correspondence Language Example Identification Number (CLEID)
- (6) Correspondence Language Manual (Utilizes CLEID)
- (7) Frequently Asked Questions – NCCI
- (8) Frequently Asked Questions – MUE
- (9) Medicare Modifier 59 Article

2.5 CMS Working in Partnership with States

2.5.1 CMS Work with Groups of States

2.5.1.1 National Association of State Medicaid Directors

The CMS responded to questions submitted by the National Association of State Medicaid Directors (NASMD) concerning implementation of the NCCI in State Medicaid programs. CMS also separately responded to NASMD's questions concerning the appeals process required for State Medicaid programs for denials of payments for Medicaid claims due to Medicaid NCCI edits and MUEs.

2.5.1.2 National Association of Medicaid Directors

The CMS also responded to questions from the National Association of Medicaid Directors (NAMD) on the appeals process required for State Medicaid programs for denials of payments for Medicaid claims due to Medicaid NCCI edits and MUEs.

2.5.1.3 Medicaid Medical Directors Learning Network

The CMS and CMS' NCCI technical contractor are working with the Medicaid Medical Directors Learning Network in implementing the NCCI in State Medicaid programs.

2.5.1.4 National Medicaid Electronic Data Interchange Healthcare (NMEH) NCCI Workgroup

The CMS held a series of conference calls with small groups of States in the NMEH NCCI Workgroup to receive input and feedback on issues involved in implementing the NCCI in State Medicaid programs. Calls were held on May 21 and 26, July 1, August 4, and September 30, 2010.

The CMS responded to two sets of questions submitted to CMS by a separate NMEH NCCI Subworkgroup on issues involved in implementing the NCCI in State Medicaid programs.

2.5.2 CMS Work with Individual States

The CMS has responded to questions on the Medicaid NCCI files from individual States, including Alabama, Florida, Minnesota, Mississippi, South Carolina, and Tennessee. Below are examples of some specific questions CMS has responded to on the implementation of the NCCI methodologies from the States:

- South Carolina on the use of modifiers in the Medicaid NCCI edits and MUEs and the application of MUEs to Medicaid claims;
- Tennessee on the application of MUEs to Medicaid claims;

- Oklahoma on the application of deactivated Medicaid NCCI edits and MUEs to Medicaid claims based on when the edits were deactivated;
- Alabama and Utah on the Medicaid NCCI APD process;
- Texas on the application of the Medicaid NCCI methodologies to Medicaid managed care organizations;
- West Virginia, Oregon, and Nevada on the effective date for State implementation of section 1903(r)(4) of the Act;
- Nevada on the consequences of noncompliance with the deadlines for implementation, NCCI “standards”, and the sources of the Medicaid NCCI edits and MUEs; and
- Vermont on available funding for State implementation of the Medicaid NCCI methodologies.

In addition, CMS has responded to questions from Maryland, Oklahoma, and Minnesota on the required appeals process in States for denials of payment for Medicaid claims due to Medicaid NCCI edits or MUEs.

The CMS has been contacted by individual States concerning implementation of the NCCI in their Medicaid program. For example, Maryland inquired about the application of the Medicaid NCCI methodologies to Medicaid claims for inpatient hospital services. The State of Washington requested to know the location of the Medicaid MUEs in a commercial off-the-shelf (COTS) software product.

2.6 CMS Work with Providers and Vendors

2.6.1 CMS Work with Providers

The Medicare NCCI methodologies are based on HCPCS / CPT coding principles and CMS Medicare policies. Most of the Medicare policies utilized in NCCI methodologies have been accepted by other third-party payers and national health care organizations.

In August 2010, CCS, LLC, at the direction of CMS, posted to its online file folder a letter to the American Medical Association, the American Hospital Association, and the Federation of American Hospitals. The letter explained the requirements of section 1903(r)(4) of the Act and CMS’ planned implementation process. These organizations circulated the letter to over 100 other health care organizations, including national medical and surgical societies and other health care professional organizations. No complaints were received about CMS’ implementation process from these organizations. Positive verbal comments were received from the American Medical Association and the American Academy of Orthopaedic Surgeons. Positive written comments were also received from the American Academy of Pediatrics.

2.6.2 CMS Responses to Questions from Providers and Vendors

CMS responded to:

- A provider in Idaho on unpublished MUEs;
- Providers in the CMS Open Forum for Physicians, Nurses & Allied Health Professionals;
- Providers in Ohio and Indiana on application of the Medicaid NCCI methodologies to Medicaid managed care plans;
- A consultant to commercial health plans in Atlanta on the Medicaid NCCI methodologies;
- Another consultant in Atlanta on the application of MUEs to Medicaid claims;
- A nonprofit organization requesting a new HCPCS codes for intensive in-home services to youth; and
- A law firm representing a corporation in the health services industry on State Medicaid Director Letter 10-017 on implementation of the NCCI methodologies in the Medicaid program.

2.7 Medicaid NCCI Workgroup

The CMS created for the Medicaid program an internal Medicaid NCCI Workgroup as a counterpart to its long-standing internal Medicare NCCI and MUE Workgroups. This workgroup consists of Medicaid program staff working on implementation of the NCCI program in Medicaid, the CMS NCCI technical support contractor, Medicaid's medical officer, Medicaid's coding specialist, program and clinical representatives from Medicare's NCCI program, and staff from CMS' Medicaid Program Integrity Group to ensure collaboration and coordination between the two NCCI programs in CMS.

The workgroup reviews changes to CPT codes and Medicaid NCCI edits and MUEs to maintain and update the Medicaid NCCI methodologies and to ensure the timely and accurate delivery to the States of the Medicaid NCCI files.

2.8 CMS Work with Technical Contractor

The principals currently with Correct Coding Solutions (CCS), LLC, have provided technical support to the Medicare program on the NCCI since the mid-1990s. The nationally recognized expert staff of CCS, LLC, developed the Medicare NCCI under the direction of the Medicare program. The Medicaid program was added to Medicare's contract with CCS, LLC, in June 2010. This contract expired in December 2010 and has been rebid.

From June to December 2010, CCS, LLC, provided all technical support to CMS concerning implementation of the NCCI in the Medicaid program. CCS, LLC, generated all of the Medicaid

NCCI files for implementation by State Medicaid programs on October 1, 2010, and January 1, 2011. The contractor provided administrative and technical support to the Medicaid NCCI Workgroup and technical expertise to CMS for responding to State questions and issues concerning implementation of the Medicaid NCCI methodologies.

3.0 IMPLEMENTATION ISSUES RAISED BY STATES

3.1 Use of Commercial Off-the-Shelf (COTS) Software to Implement the NCCI in State Medicaid Programs

Many, if not most, States use, at least in part, COTS software to edit the Medicaid claims they receive for reimbursement. A number of States have proposed using such software to implement the Medicaid NCCI methodologies into their MMISs.

In response to inquiries regarding the use COTS Software to implement the NCCI in the State Medicaid Programs, CMS' response has been the following:

- Section 1903(r)(4) of the Act made the NCCI methodologies the primary edits for processing Medicaid claims for payment. Other edits, whether from the State or from vendors, are now secondary in importance. State MMISs can still use these additional edits for processing Medicaid claims for payment, if a State Medicaid program wishes to do so, but these additional edits cannot substitute for the NCCI edits and MUEs contained in the Medicaid NCCI methodologies.
- States must incorporate, and operationally utilize, the official national Medicaid NCCI files, which CMS posts on the MII WorkSpace Web site, without any changes (“natively”). Only State use of the official national standard Medicaid NCCI methodologies and files that CMS provides for each calendar quarter complies with the requirements of section 1903(r)(4) of the Act.
- If a State wishes to use additional edits to process its Medicaid claims, these additional edits must “wrap” around the core of the Medicaid NCCI edits and MUEs. CMS has requested that State Medicaid programs report to CMS through the APD process what these additional edits are.
- If a State wishes to deactivate any of the NCCI edits and MUEs in the official national Medicaid NCCI files, the State can request CMS approval to do so through the APD process, if the State can document to CMS that the edits the State wishes to deactivate conflict with State law, regulation, administrative rule, or payment policy.
- A State Medicaid program cannot substitute the Medicare NCCI files for the Medicaid NCCI files or attempt to derive on its own the Medicaid NCCI files from the Medicare NCCI files. Both the Medicare and Medicaid NCCI files are updated quarterly, the divergence between the two sets of files will grow over time, and States will not know all of the changes made in the Medicaid NCCI files from one quarter to the next quarter.

The Medicaid NCCI files in one quarter are a complete replacement of the Medicaid NCCI files from previous quarters.

- Similarly, a State Medicaid program may use vendor COTS software to implement the NCCI methodologies. However, if a State does so, then the State must ensure that such COTS software fully and correctly incorporates the Medicaid NCCI files each calendar quarter.
- Through the APD process, CMS will provide 90 percent FFP for State expenditures for planning, design, development, installation, and enhancement activities to enable the State's MMIS to incorporate and operationally utilize without changes the official national Medicaid NCCI files that CMS provides to States on the MII WorkSpace Web site each calendar quarter for processing Medicaid claims in the State.⁸ Such changes must also conform to the framework and standards of the Medicaid Information Technology Architecture (MITA).
- On November 8, 2010, CMS issued a Notice of Proposed Rule Making (NPRM) (CMS-2346-P) on proposed policies and standards for State Medicaid eligibility systems. National policies and standards for State eligibility systems will be adopted in the future. CMS is committed to ensuring that enhanced FFP is provided to States to continuously and adequately adopt national files, such as the Medicaid NCCI files, and fund the development of State MMISs that are capable of incorporating and operationally utilizing national policies, standards, and files.
- The CMS encourages States to download from the MII WorkSpace Web site, incorporate into their MMISs, and operationally utilize the official national Medicaid NCCI files for each calendar quarter without any changes. CMS does not support or advocate any one solution over another. States can decide which solution works best considering their current infrastructure for processing Medicaid claims. CMS is only requiring that States have a solution or approach that fully and correctly implements the Medicaid NCCI methodologies for each calendar quarter.
- If a State does utilize a COTS product in processing its Medicaid claims, then the State also must:
 - first attribute savings in payments for Medicaid claims to the Medicaid NCCI edits and MUEs;
 - ensure that there is no duplication of edits between the Medicaid NCCI files and the COTS claims-editing product;

⁸ The CMS does not provide any FFP for the development or modification of any software which a State does not own. CMS will provide 90 percent FFP to develop or modify State-owned software to interface its MMIS with software that the State does not own. CMS will provide 75 percent FFP for a State Medicaid program to license proprietary software for its MMIS.

- distinguish between the effects of the Medicaid NCCI edits and MUEs and any other State or COTS software edits in regard to program savings, denials of reimbursement for Medicaid claims, appeals of denials of payment for Medicaid claims, and reports of data on measures requested by CMS through the APD process; and
 - report separately any additional savings achieved by the State's own edits or by the COTS product.
- The CMS is providing additional guidance to State Medicaid programs on this issue.

It is important that CMS ensure that States (1) use correct Medicaid NCCI edit tables; (2) do not deactivate edits after March 31, 2011, unless CMS has given prior approval to deactivate; (3) apply Medicaid NCCI methodologies to the correct types of services; (4) apply Medicaid NCCI methodologies utilizing proper claims adjudication rules; (5) provide providers an appropriate appeal process for claims denied due to Medicaid NCCI methodology edits; and (6) provide patient protections to ensure that providers do not bill patients for services denied due to NCCI or MUE edits.

3.2 Requirement for a Formal Appeals Process in States for Denial of Payment for a Service on Medicaid Claims Due to NCCI Edits and MUEs

Section 2.2 of this Report lists the five NCCI methodologies. The Medicaid NCCI methodologies are derived from the Medicare NCCI methodologies. CMS found all five Medicare NCCI methodologies to be compatible with the Medicaid program. Consequently, State Medicaid Director Letter 10-017 on implementation of the NCCI methodologies in State Medicaid programs required States to implement all five NCCI methodologies in processing Medicaid claims as October 1, 2010, as required by section 1903(r)(4) of the Act.

Section 2.2 of this Report also lists the four components of each of the five NCCI methodologies. One of these four components is a process for a provider to appeal denial of payment for a service on a claim due to an NCCI edit or a MUE. This is one of the four required components of each of the five Medicare NCCI methodologies because Medicare is required to have such a process. Consequently, when State Medicaid Director Letter 10-017 required States to implement all five NCCI methodologies, it also de facto required the States to implement all four components of each of the five NCCI methodologies, including a process for providers to appeal denials of payment due to an NCCI edit or MUE.

In response to this latter requirement, a number of States communicated to CMS that they have no formal process in place for provider appeals of denied claims in their Medicaid programs. These States stated that establishing and operating such a formal process would be a financial and operational hardship for them, particularly at this time.

Upon further investigation, CMS found that many State Medicaid programs lack a formal process for provider appeals of denied claims. However, State Medicaid programs do allow providers to submit additional documentation to validate denied claims, to resubmit claims, and,

in some States, to call a hotline that will inform them about submitting claims to the State's Medicaid program. Since many State Medicaid programs lack a formal process for provider appeals of denied claims, CMS has decided to remove this requirement at this time because it is not compatible with the Medicaid program. CMS is issuing a new State Medicaid Director Letter informing State Medicaid Directors of this change.

4.0 CONCLUSIONS

Some State Medicaid programs had not implemented the (Medicare) NCCI methodologies prior to the passage of the Affordable Care Act in March 2010. Consequently, some State Medicaid programs were not familiar with the NCCI methodologies and their complexities when the Affordable Care Act was passed.

In addition, many State Medicaid programs have dated legacy MMISs that lack the capability to download the Medicaid NCCI files unchanged for each calendar quarter. Significantly upgrading State MMISs is a major, complex undertaking that takes considerable amounts of time and financial resources, which most States presently lack. However, in accordance with section 1903(r) of the Act, CMS is providing 90 percent FFP to State Medicaid programs to enable them to upgrade their MMISs, so that their new MMISs will be able to download on a regular basis the Medicaid NCCI files and other official, national, standard files without changes.

Consequently, for the above reasons, the statutory deadline in section 1903(r)(4) of the Act for States to use the NCCI methodologies to process their Medicaid claims filed on or after October 1, 2010, presented a major challenge for most State Medicaid programs. CMS will continue to work with State Medicaid programs and provide them with the technical and financial resources they need in order to upgrade their MMISs and implement the Medicaid NCCI methodologies as quickly as possible.

This will be a long-term undertaking for both CMS and the States. The rate at which these two goals can be accomplished depends primarily on the amount of financial resources that will be available at both the Federal and State levels. However, CMS strongly believes that the returns on these investments at the Federal and State levels will far exceed the amounts of these investments, both in terms of strengthening the integrity of the Medicaid program and in terms of financial savings.

5.0 APPENDICES

APPENDIX A: STATE MEDICAID DIRECTOR LETTER 10-017

APPENDIX B: ADVANCE PLANNING DOCUMENT (APD) TEMPLATE FOR IMPLEMENTATION OF THE NATIONAL CORRECT CODING INITIATIVE (NCCI) IN A STATE'S MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

APPENDIX A

STATE MEDICAID DIRECTOR LETTER 10-017

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey & Certification

SMD #: 10-017
ACA#: 7

September 1, 2010

Re: National Correct Coding Initiative

Dear State Medicaid Director:

This letter is one of a series intended to provide guidance on the implementation of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act. Specifically, this letter provides initial guidance regarding Title VI – Transparency and Program Integrity, Subtitle F – Additional Medicaid Program Integrity Provisions, Section 6507 – Mandatory State Use of National Correct Coding Initiative (NCCI).

For ease of reference, this letter is organized into the following subject areas:

- Statutory Requirements;
- Definitions of NCCI, NCCI Methodologies, and the Application of NCCI Methodologies in Medicare;
- Implementation of NCCI Methodologies in Medicaid;
- Resources for Implementing NCCI Methodologies in State Medicaid Programs;
- Additional Important Distinctions between Medicaid and Medicare NCCI Methodology Files¹;
- Funding for State Implementation of NCCI Methodologies in Medicaid and the Use of the Advanced Planning Document (APD);

¹ Enclosure B contains a section discussing the differences between Medicaid NCCI and MUE files and those of Medicare. This information may be of interest to individuals familiar with the Medicare NCCI/MUE edits.

- Report to Congress;
- Commercial Off-the-Shelf (COTS) Software and Its Application to Medicaid NCCI Methodologies; and
- Contacts for States.

Statutory Requirements

Section 6507 of the Affordable Care Act amends section 1903(r) of the Social Security Act (the Act). Section 1903(r)(4) of the Act, as amended, requires CMS to take three specific actions by September 1, 2010. First, CMS must notify States of NCCI methodologies that are “compatible” with claims filed with Medicaid to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. Second, CMS must notify States of the NCCI methodologies (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) that should be incorporated for claims filed with Medicaid for which no national correct coding methodology has been established for Medicare. Third, CMS must inform States as to how they must incorporate these methodologies for claims filed under Medicaid. By March 1, 2011, CMS must submit a report to Congress that includes the September 1, 2010, notice to States and an analysis supporting these methodologies. Section 1903(r)(1)(B)(iv), as amended, requires that States incorporate compatible methodologies of the NCCI administered by the Secretary and such other methodologies as the Secretary identifies, effective for Medicaid claims filed on or after October 1, 2010.

Definitions of NCCI, NCCI Methodologies and Edits, and the Application of NCCI Methodologies in Medicare

- NCCI. The NCCI is a CMS program that consists of coding policies and edits. Providers report procedures/services performed on beneficiaries utilizing Healthcare Common Procedure Coding System (HCPCS) codes. These codes are submitted on claim forms to Fiscal Agents for payment. NCCI policies and edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service. This program was originally implemented in the Medicare program in January 1996 to ensure accurate coding and reporting of services by physicians. The coding policies of NCCI are based on coding conventions defined in the American Medical Association’s Current Procedural Terminology Manual, national and local Medicare policies and edits, coding guidelines developed by National societies, standard medical and surgical practice, and/or current coding practice.
- NCCI Methodologies. NCCI methodologies have four components: 1) a set of edits; 2) definitions of types of claims subject to the edits; 3) a set of claims adjudication rules for applying the edits; and 4) a set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.
- NCCI Edits. The NCCI edits are defined as edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits: 1) NCCI edits, or procedure-to-procedure edits that define pairs of HCPCS/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and 2) Medically Unlikely Edits (MUEs), or units-of-service edits that define for each HCPCS/CPT

code the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g., claims for excision of more than one gallbladder or more than one pancreas).

Application of NCCI Methodologies in Medicare

The CMS developed NCCI for Medicare to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B (practitioner) fee-for-service claims. Enclosure A provides a history of the NCCI in Medicare.

Currently, CMS has five methodologies for Medicare Part B. Specifically, these are:

- (1) NCCI procedure-to-procedure edits for practitioner and ambulatory surgical center (ASC) services.
- (2) NCCI procedure-to-procedure edits for outpatient hospital services (including emergency department, observation, and hospital laboratory services) incorporated into the Medicare outpatient code editor (OCE) for hospitals reimbursed through the hospital outpatient prospective payment system (OPPS). These same edits in OCE are applied to all facility therapy services billed to the Medicare Fiscal Intermediary (Part A Hospital/Part B Practitioner Medicare Administrative Contractors (A/B MACs) processing claims with the Fiscal Intermediary Shared System (FISS)). They do not apply to hospitals not reimbursed through the OPPS (e.g., Critical Access Hospitals (CAHs)).
- (3) MUE units-of-service edits for practitioner and ASC services.
- (4) MUE units-of-service edits for outpatient hospital services for hospitals reimbursed through the OPPS and for CAHs.
- (5) MUE units-of-service edits for supplier claims for durable medical equipment.

Implementation of NCCI Methodologies in Medicaid

Compatible Methodologies for Medicaid

After careful consideration, we have determined that the five NCCI methodologies listed above currently in place in Medicare are compatible methodologies for claims filed in Medicaid. Thus, consistent with the statute, by September 1, 2010, CMS will make available to States all five NCCI methodologies compatible with Medicaid. In addition, we have determined that there are currently no other methodologies compatible for Medicaid since there are no other national correct coding methodologies being used by Medicare. States must incorporate all five methodologies into their Medicaid Management Information Systems (MMISs) and begin the process of editing claims against these five NCCI methodologies effective for claims filed on or after October 1, 2010. Since the Medicaid methodology files will contain confidential information about Medicare NCCI/MUE edits that is not public information, State Medicaid agencies should **NOT** share the Medicaid NCCI methodology files with vendors or other parties which are not State-contracted Fiscal Agents (or State-contracted entities that perform claims processing activities on behalf of State Agencies, or "State-contracted entities" for purposes of this letter.)

In considering the current financial status of States and the savings that are possible as a result of proper coding, CMS continues to evaluate the application of NCCI methodologies, where the methodologies are not applied by Medicare, but are found to be compatible with Medicaid. These methodologies may be developed later, and CMS will update States regarding the progress of NCCI methodologies in Medicaid, as appropriate, moving forward.

State Flexibility in Incorporating “Edits”

We realize that States are in different stages in implementing correct coding edits into their Medicaid programs. Some States have fully incorporated procedure-to-procedure and MUE units of service edits into their Medicaid claims. Some States have incorporated edits for particular sets of services, while other States are just beginning to explore these edits for Medicaid. The five Medicare NCCI methodologies currently contain approximately 1.3 million procedure to procedure and MUE units of service edits. We understand the challenges that many States would face in entirely incorporating these edits into their Medicaid claims processing systems.

Consequently, CMS has provided flexibility in implementing NCCI in Medicaid. All five Medicaid NCCI methodologies must be incorporated into Medicaid MMISs effective for claims filed on or after October 1, 2010. However, CMS has withheld a small number of edits from the five Medicare NCCI/MUE methodologies because of concerns about their compatibility with the Medicaid program. We also recognize that there may be additional incompatible edits. If a State Fiscal Agent (or State-contracted entities) identifies such incompatible edits, please report them to our contractor, Correct Coding Solutions, LLC, as soon as they are identified. (See the Contacts for States section of this guidance for more information regarding Correct Coding Solutions, LLC.)

Additionally, CMS continues to review NCCI/MUE edits and as we move forward to update files quarterly, additional compatible or incompatible edits will be added to or deleted from Medicaid NCCI/MUE files, as appropriate.

State Flexibility in Deactivating Edits

States may consider edits on an individual State by State basis. That is, if a State has determined that some portion of the 1.3 million edits conflict with State laws, regulations, administrative rules, payments policies, and/or level of operational readiness, CMS will allow State deactivation of edits. This flexibility is granted until such time as the earlier of:

1. April 1, 2011, or
2. The date at which the State has an Advanced Planning Document (APD) approved by CMS that documents such conflict with State laws, regulations, administrative rules, payment policies, and/or the State’s level of operational readiness.

Requesting Deactivation of Edits

The CMS will use the MMIS-APD to approve State deactivation of edits after review of the submission of State documentation confirming that the use of certain procedure-to-procedure or MUE units of service edits is in direct conflict with State laws, regulations, administrative rules, payment policies, and/or the State’s level of operational readiness. States must submit an APD to CMS by no later than March 1, 2011, for review and approval of deactivation of edits, if they want to

continue after March 31, 2011, to deactivate relevant edits. States will not be afforded the flexibility to deactivate edits after March 31, 2011, because of lack of operational readiness. If States are not deactivating edits after March 31, 2011, States are not required to submit an APD to CMS for this purpose.

While MCDNCCI files will be updated on a quarterly basis, States will not be required to submit to CMS for review and approval an APD each quarter to deactivate edits that remain in conflict with State laws, regulations, administrative rules, and/or payment policies. States will, however, be required to update APDs each quarter and as otherwise necessary if changes to State laws, regulations, etc. occur and/or if States wish for CMS to approve additional/revised edits to be deactivated.

State Flexibility to Incorporate NCCI Methodologies/Edits beyond CMS' Requirements

States can apply additional NCCI methodologies to service types not currently implemented in the Medicare context, in order to promote correct coding and reduce the error rate for claim payments. For example, in reviewing the Medicare model, CMS considered that the Medicare NCCI methodologies are applicable to types of service: procedure-to-procedure and MUE edits for practitioner services, ASC services, outpatient hospital services, and so forth.

Currently, Medicare NCCI methodologies are not in place for facility claims from long term care facilities, Medicare Advantage plans, or other hospitals that are not paid using OPPS (e.g., CAHs). States should contact CMS to discuss/receive approval to incorporate additional NCCI methodologies and/or edits in their claims processing systems.

Enclosure B provides further information on the nature and structure of the NCCI methodologies in Medicaid, including the definition of the NCCI methodology, a description of NCCI procedure-to-procedure edits and MUE units-of-service edits, a description of the five Medicaid NCCI methodologies (herein referred to as the MCDNCCI) for implementation by State Medicaid programs, identification of the edits included in the five MCDNCCI methodologies, and a discussion of the significant differences between MCDNCCI and Medicare NCCI/MUE.

Resources for Implementing NCCI Methodologies in State Medicaid Programs

The MCDNCCI methodology files will be available for download only to States by September 1, 2010, and only on the Medicaid Integrity Institute's (MII) secure Web site known as "Workspace." Quarterly updates of the MCDNCCI files will be posted to Workspace.

Currently, each State has only one user license for Workspace. For information regarding who in your State has access to this Web site, please contact Mr. Robb Miller, Director of the Division of Field Operations, Medicaid Integrity Group, Center for Program Integrity, at 312-353-0923 or via e-mail at Robb.Miller@cms.hhs.gov. For the time being, we will not be able to issue any additional user licenses. You may, however, choose to reassign your State's user license to another individual. The MCDNCCI files will be available in three file formats: ASCII.TXT, Excel 2007 (.xlsx), and tab-delimited text (.txt) with column headings.

Further technical guidance entitled the *Medicaid NCCI (MCDNCCI), MCDNCCI File Names and Formats, Algorithms for Processing Claims, and Characteristics of Edits* is provided to States'

information systems staff to facilitate download and correct use of the MCDNCCI ASCII.TXT files. This information is necessary to understand each field in each edit. The claims adjudication algorithm will assist information systems staff to program their systems to correctly adjudicate NCCI and MUE edits against claims. It will also be very helpful to medical review staff, appeals staff, medical directors, fraud and abuse contractors, and others who need to know the details about how NCCI edits and MUEs are applied to claims.

This technical guidance also provides a description of the edit files. This information will be available on both the MII and on a new Medicaid NCCI webpage on the CMS Web site.

The Excel 2007 (.xlsx) file and the tab-delimited text (.txt) file with column headings will also be available on the Medicaid NCCI webpage by October 1, 2010.

It is important for State Medicaid programs and their Fiscal Agents (or State-contracted entities), to avoid three common errors that result in incorrect application of NCCI/MUE edits.

- **Common Error 1:** The edits apply only to services by the same provider, to the same beneficiary, on the same date of service. If an MCDNCCI edit is applied to any situation other than the same provider, the same beneficiary, and the same date of service, it should NOT be attributed to the MCDNCCI.
- **Common Error 2:** NCCI procedure-to-procedure edits with a modifier indicator of “1” must allow use of NCCI-associated modifiers to bypass the edit. This requirement is described further in the *Medicaid NCCI (MCDNCCI), MCDNCCI File Names and Formats, Algorithms for Processing Claims, and Characteristics of Edits* technical guidance. This document also includes information regarding NCCI-associated modifiers.
- **Common Error 3:** MUE units-of-service edits are claim-line edits. They are not edits for an entire claim or entire date of service. Each claim line must be adjudicated separately against the MUE value for the HCPCS/CPT code on the claim line. All units-of-service for the same code on the entire claim or the same date of service should NOT be summed and compared to the MUE value. See also the *Medicaid NCCI (MCDNCCI), MCDNCCI File Names and Formats, Algorithms for Processing Claims, and Characteristics of Edits* technical guidance.

Reimbursement for a claim denied due to an NCCI/MUE edit may be appealed. The *MCDNCCI Claim Appeals Process* guidance provides separately the rules for adjudicating appeals of denied reimbursement due to MCDNCCI edits. This guidance document will be posted to the MII and to the Medicaid NCCI webpage.

The CMS is developing a separate policy manual for Medicaid services derived from the *National Correct Coding Initiative Policy Manual for Medicare Services*. The *National Correct Coding Initiative Policy Manual for Medicaid Services* will be available to Fiscal Agents (or State-contracted entities), on the Medicaid NCCI webpage on the CMS Web site by October 1, 2010. This manual will be helpful in understanding the policies that the NCCI and MUE edits are based on and will assist customer service, medical review, and appeals staffs.

The CMS will also post the *NCCI Correspondence Language Manual* to the new Medicaid NCCI webpage on the CMS Web site. Each NCCI edit and MUE has a “Correspondence Language

Example Identification Number” (CLEID). The *NCCI Correspondence Language Manual* must be used with the CLEID for correspondence related to the policy rationale for each edit. This information will also be posted to the MII and to the Medicaid NCCI webpage. The *NCCI Correspondence Language Manual* is helpful to the claims processing staffs of Medicaid Fiscal Agents (or State-contracted entities), in explaining the basis of an edit when responding to correspondence and to staff handling appeals.

The CMS will also make available Frequently Asked Questions for NCCI and for MUE as well as a Medicare Modifier 59 Article. Enclosure C provides States implementing NCCI methodologies in State Medicaid programs with a list of these resources and the timeframes and methods for securing these resources.

Additional Important Distinctions between Medicaid and Medicare NCCI Methodology Files

In order to ensure that States have the NCCI methodology files in a timely manner, for the start of this program, the Medicaid NCCI methodology files will lag the corresponding Medicare NCCI/MUE files by one calendar quarter with two exceptions:

- The Medicaid NCCI methodology file for outpatient hospital services will not lag by one calendar quarter. The Medicaid and Medicare files for these services will be synchronous.
- Medicaid will incorporate into its NCCI methodology files Medicare NCCI and MUE edit deletions or modifications on a synchronous basis with Medicare.

Beginning with the calendar quarter starting January 1, 2011, all Medicaid NCCI methodology files will be synchronous with Medicare NCCI and MUE edit files. This would mean that for version 2.0 (January 1, 2011) and all subsequent versions of the MCDNCCI, the files will be available on the MII approximately 15 days prior to the beginning of the calendar quarter.

Funding for State Implementation of NCCI Methodologies in Medicaid and the Use of the APD

Section 1903(r) of the Act requires State MMISs to include Medicaid NCCI methodologies as part of their functionality. Section 1903(a)(3) of the Act provides CMS with the authority to provide 90-percent Federal financial participation (FFP) to States for design, development, and installation, and 75-percent FFP for maintenance and operations of the State’s MMIS system. Thus, in considering revisions to a State’s MMIS, CMS is authorized to provide FFP to States to incorporate Medicaid NCCI methodologies into the State’s MMIS system.

States should utilize the current MMIS-APD process for requesting such funding for a State MMIS. Additionally, if a State can verify to CMS that the State was involved in making changes to its MMIS to incorporate NCCI methodologies prior to the release date of this letter, retroactive FFP may be available for APD-approved activities, but for no earlier than March 23, 2010. States should work with their respective Regional Offices to submit APDs and to request FFP.

Report to Congress

The CMS is required by section 1903(r)(4)(B) of the Act (as added by section 6507 of the Affordable Care Act) to submit to Congress, no later than March 1, 2011, a report that includes the September 1,

2010 notice to States and an analysis supporting the identification of the methodologies for Medicaid. States will be required to report through the APD to CMS:

- how many edits were deactivated;
- what types of edits were deactivated;
- the rationale for deactivating certain edits;
- the process and the workload for State staff that deactivating edits created;
- how many claims would have been denied if it were not for the deactivations;
- how many claims would have gone to appeal if it were not for the deactivations;
- the total amount of dollars that were paid as a result of the deactivations;
- the total number of providers that would have had denied claims if it were not for the deactivations; and
- any additional information that is necessary in order to determine the impact that deactivation of edits has had on providers and States alike.

Additionally, States will be required to report the savings accrued as a result of the NCCI initiative in Medicaid.

The CMS will convene a multi-disciplinary team to review APDs submitted by States. Further, CMS plans to develop an MMIS-APD template specific to NCCI for State convenience. Once the APD template is developed, we will provide information for retrieving the document.

COTS Software and Its Application to Medicaid NCCI Methodologies

CMS provides information describing the requirements for COTS software and vendors implementing NCCI methodologies on behalf of the State on the MII and on the Medicaid NCCI webpage.

CMS requires that, for those States that use COTS vendors to perform claims processing activities on behalf of the State Agencies that receive NCCI methodologies in advance of the general public, confidentiality agreements must be in place to ensure the confidentiality of all information not available to the general public contained in the NCCI methodology files. Further, any requests for confidential information, including the release of edits received by State fiscal agents or State-contracted entities performing claims processing activities on behalf of the State agencies, must be reported to the State agency.

We wish to remind States that they have a responsibility to ensure that any entities that contract with them comply with all contract requirements, including issues of confidentiality. If it is found that COTS vendors that perform claims processing activities on behalf of State Agencies have used Medicaid NCCI file information for other than Medicaid business, or have shared confidential edits with other third parties, States must consider imposing penalties against such vendors. Vendors and the general public will have access to the Medicaid NCCI methodology edits each quarter when they are posted on the new Medicaid NCCI webpage on the CMS Web site on the first day of each calendar quarter. However, the MCDNCCI edit file information available on the CMS Web site will not contain all information in the MCDNCCI methodology files provided to the States.

Contacts for States

Below is a list of contacts for States to use in implementing this program. Specifically, for questions related to:

- the MCDNCCI program, please contact Rick Friedman, Director, Division of State Systems, Center for Medicaid, CHIP and Survey & Certification, at 410-786-4451;
- individual claims, please contact your Fiscal Agent (or State-contracted entities); and
- reconsideration of MCDNCCI edits, please contact Correct Coding Solutions, LLC (CCS LLC).

States may also direct questions to the CMS Medicare NCCI contractor, CCS LLC, who can be contacted at:

Medicaid National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907
Facsimile: 317-571-1745

Additionally, CMS will post information to the CMS Web site and to the MII, including further instruction regarding such issues as the effective date of edits that have been deactivated by States.

The CMS looks forward to working with you to implement this important legislation.
Sincerely,

/s/

Cindy Mann
Director

Enclosure A – History of the NCCI in Medicare
Enclosure B – Nature and Structure of Medicaid’s NCCI
Enclosure C – Resources for States in Implementing National Correct Coding Initiative Methodologies in Medicaid

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children’s Health

Rick Fenton
Acting Director
Health Services Division
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Carol Steckel
President
National Association of Medicaid Directors

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

ENCLOSURE A

HISTORY OF THE NCCI IN MEDICARE¹

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) was enacted. Section 6102 of P.L. 101-239 amended Title XVIII of the Social Security Act (the Act) by adding a new section 1848, "Payment for Physicians' Services". This section of the Act provided for replacing the previous reasonable charge mechanism of actual, customary, and prevailing charges with a resource-based relative value scale (RBRVS) fee schedule that began in 1992.

With the implementation of the Medicare Physician Fee Schedule, it was important to ensure that uniform payment policies and procedures were followed by all carriers (A/B MACs processing practitioner service claims), so that the same service would be paid similarly in all carrier (A/B MAC processing practitioner service claims) jurisdictions. Accurate coding and reporting of services by physicians is a critical aspect of assuring proper payment.

The NCCI replaced and is more comprehensive than the "rebundling" program instituted by CMS, formerly HCFA, in 1991. Since the NCCI is a CMS program, its policies and edits represent CMS national policy. However, NCCI policies and edits do not supersede any other CMS national coding, coverage, or payment policies.

The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. Medicare carriers implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.²

Although the NCCI was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) to process Part B practitioner/ASC claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI. Effective January 2006, all therapy claims paid by Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims) were also subject to NCCI edits in the OCE.

NCCI edits incorporated into OCE appear in OCE one calendar quarter after they appear in NCCI. Hospitals like physicians and other providers must code correctly even in the absence of NCCI or OCE edits. For example, new category I CPT codes are generally effective on January 1 each year, and many new edits for these codes appear in NCCI on January 1. However, the new edits for these codes do not appear in OCE until the following April 1. Hospitals must code correctly during the three-month delay.

¹ Centers for Medicare & Medicaid Services (CMS), NCCI Policy Manual for Medicare Services, Version 15.3 – Effective October 1, 2009, pp. viii – ix.

² <http://www.cms.gov/NationalCorrectCodInitEd/>

On January 1, 2007, CMS incorporated Medically Unlikely Edits (MUEs) into the NCCI program. These edits are applicable to claims submitted to Carriers (A/B MACs processing practitioner service claims), A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Fiscal Intermediaries (FIs) A/B MACs processing outpatient hospital service claims).

ENCLOSURE B

NATURE AND STRUCTURE OF MEDICAID'S NCCI

The Patient Protection and Affordable Care Act (the Affordable Care Act) requires Medicaid to adopt NCCI methodologies. An NCCI methodology consists of four components:

- (1) A set of edits.
- (2) Definition of types of claims subject to the edits.
- (3) A set of claims adjudication rules for applying the edits.
- (4) A set of rules for addressing provider/supplier appeals of denied services based on the edits.

This Enclosure B addresses the edit sets and types of claims subject to the edits. The claim adjudication rules are posted to the new Medicaid NCCI webpage and the rules for adjudicating appeals of denied services are on this webpage as well.

NCCI methodologies only apply to services performed by a single provider to a single beneficiary on the same date of service.

NCCI methodologies consist of two types of edits:

- (1) NCCI procedure-to-procedure edits are pairs of HCPCS/CPT codes consisting of a column one code and a column two code. The edit defines two codes that should not be reported together for a variety of reasons. If both codes are reported, the column one code is eligible for payment and the column two code is denied. However, for many edits, there are circumstances where both the column one code and column two code are eligible for payment. These circumstances are identified by the modifier indicator for each edit which is discussed in the Edit Characteristics Document provided on the Medicaid NCCI webpage.
- (2) MUE units of service edits define for each HCPCS/CPT code the number of units of service that are unlikely to be reported if the claim is reported correctly. MUEs are applied separately to each line of a claim, NOT all units of service for a code on a single date of service. If more units of service are reported for the HCPCS/CPT code on a claim line than the MUE value for the code on that claim line, the entire claim line is denied. The claims processing contractor during the automated processing of the claim should NOT pay any units of service on the claim line if the MUE is triggered for a claim line. The provider/supplier will have to resubmit the claim if the Fiscal Agent (or the State-contracted entity that performs claims processing activities on behalf of the State Agency), permits this process or will have to appeal the claim line denial to receive payment for any units of service denied based on an MUE. For some procedures (e.g., colectomy), the MUE is an absolute limit. However, for other procedures, providers/suppliers may occasionally report units of service in excess of the MUE value by reporting the same code on more than one line of a claim with appropriate coding modifiers.

CMS is developing the Medicaid NCCI (MCDNCCI) edits based on Medicare NCCI and MUE edits and their underlying principles. Pursuant to the requirements of the Affordable Care Act, Medicaid is adopting most Medicare NCCI and MUE edits and the policies on which they are based. Since there is not adequate time to review all Medicare policies forming the basis for Medicare NCCI and MUE edits prior to the September 1, 2010 deadline for providing MCDNCCI to the States, CMS anticipates that it will review many of the underlying policies in the future and has the option to modify some of them and the edits based on them for Medicaid.

The CMS has identified five NCCI methodologies for implementation in State Medicaid programs:

- (1) NCCI procedure to procedure edits for practitioner and ambulatory surgical center (ASC) services derived from Medicare NCCI for practitioners and ASCs.
- (2) NCCI procedure to procedure edits for outpatient hospital services and all facility therapy services derived from Medicare NCCI edits for outpatient hospital services incorporated into Medicare OCE (outpatient code editor) for OPPTS (outpatient prospective payment system) hospitals.
- (3) MUE units of service edits for practitioner and ASC services derived from Medicare MUE for practitioners and ASCs.
- (4) MUE units of service edits for outpatient hospital services derived from Medicare MUE for outpatient hospital services.
- (5) MUE units of service edits for supplier claims for durable medical equipment derived from Medicare MUE for durable medical equipment.

The MCDNCCI available to States on September 1, 2010, will contain most Medicare NCCI/MUE edits for each of the five methodologies. MCDNCCI methodology files will be updated each calendar quarter. The first version is labeled version 1.3. The second version for January 1, 2011, will be version 2.0.

DIFFERENCES BETWEEN MEDICAID NCCI AND MEDICARE NCCI/MUE

Individuals familiar with Medicare NCCI/MUE will note two significant differences in Medicaid NCCI methodologies.

- (1) Medicaid NCCI procedure-to-procedure edits for each of the two methodologies will have a single CCE (Column one/Column Two Correct Coding Edit) file rather than separate CCE and ME (mutually exclusive) edit files as Medicare utilizes. Medicaid combined the Medicare CCE and ME files into a single CCE file. This change simplifies the use of MCDNCCI files posted on the CMS Web site. It also simplifies the use of MCDNCCI methodology files for Fiscal Agent (or State-contracted entity staff that perform claims processing activities on behalf of the State Agency), customer service, medical review, and appeals staff.
- (2) Medicaid NCCI procedure to procedure edits do not have a re-bundling (previous edit) indicator as Medicare edits have. This indicator is used by Medicare to indicate that an edit was included

in the Medicare Rebundling project from the early 1990s. This concept is not relevant to the Medicaid program.

Although the Medicaid NCCI methodology files initially only include edits also in Medicare NCCI/MUE, CMS anticipates that in the future MCDNCCI will include additional edits for codes not paid by Medicare, but paid by Medicaid.

The initial Medicaid NCCI methodology files do not include all edits in Medicare NCCI/MUE (i.e., MCDNCCI does not include certain groups of edits that require further evaluation by CMS).

ENCLOSURE C

**RESOURCES FOR STATES IN IMPLEMENTING NATIONAL
CORRECT CODING INITIATIVE METHODOLOGIES IN MEDICAID**

Name	When Resource Will Be Available	How States Will Obtain Resource
Medicaid NCCI Methodology Files for State Medicaid Agencies and Fiscal Agents to Download	September 1, 2010	Medicaid Integrity Institute
Medicaid NCCI Methodology Files on CMS Web site (Excel and Tab Delimited TXT files)	October 1, 2010	Medicaid NCCI page on the CMS Web site
Medicaid NCCI and MUE Claims Processing Rules, File Names and Formats, Characteristics of Edits, Use of CLEID, and Appeal Adjudication Rules	September 1, 2010	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site
MCDNCCI Claim Appeals Process	September 1, 2010	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site
Correspondence Language Example Identification Number (CLEID)	September 1, 2010	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site
<i>National Correct Coding Initiative Policy Manual for Medicaid Services</i>	October 1, 2010	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site
<i>Correspondence Language Manual (Utilizes CLEID)</i>	October 1, 2010	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site
Frequently Asked Questions - NCCI	Published upon availability	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site
Frequently Asked Questions - MUE	Published upon availability	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site
Medicare Modifier 59 Article	September 1, 2010	Medicaid Integrity Institute and the Medicaid NCCI page on the CMS Web site

APPENDIX B

**ADVANCE PLANNING DOCUMENT (APD) TEMPLATE FOR IMPLEMENTATION
OF THE NATIONAL CORRECT CODING INITIATIVE (NCCI) IN A STATE'S
MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)**

Name of State: _____

Name of State Medicaid Agency: _____

Name of Contact in State Medicaid Agency: _____

E-Mail Address of Contact in State Medicaid Agency: _____

Telephone Number of Contact in State Medicaid Agency: _____

Date of Submission to CMS Regional Office: _____

DISCLAIMERS

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information by an agency of the Federal government, unless it displays a valid OMB control number. The OMB control number for this information collection has not yet been issued. Consequently, submission of the information requested in this document is not required until such a control number has been issued.

For the definition of an Advance Planning Document (APD) in Federal regulations, see 45 CFR, Part 95, Subpart F.

A State is requested to submit this APD to its CMS Regional Office in accordance with:

- the State Medicaid Director letter, SMD #10-017, ACA #7, dated September 1, 2010, on the NCCI and
- the following Federal law and regulations regarding Medicaid systems operations and conditions for Federal financial participation (FFP):
 - Federal Social Security Act, Title XIX, 42 USC 1396 et seq.
 - 45 CFR Part 92
 - 45 CFR Part 95, Subpart F
 - 42 CFR Part 433, Subpart C
 - Part II, Section 11 of the Medicaid Manual
 - 45 CFR 205.37(a)(1)-(8)
 - 45 CFR 307.15.

The time required to complete this information collection is estimated to average one hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

A State must obtain prior written approval from the appropriate, authorized Federal agency before expending any funds that may be eligible for Federal financial participation (FFP).

45 CFR allows CMS a maximum of 60 days to review APDs before providing a response to a State.

INTRODUCTION

The purpose of this document is to provide information and a template to States for submitting an Advance Planning Document (APD) to their CMS Regional Offices for implementing the National Correct Coding Initiative (NCCI) in their Medicaid programs. The process and requirements for implementing the NCCI in Medicaid are described in the State Medicaid Director letter on the NCCI, SMD #10-017, ACA #7, dated September 1, 2010.

This APD template incorporates both “planning” and “design, development, installation, and enhancement” activities for incorporating the NCCI into a State’s Medicaid Management Information System (MMIS). It combines a “planning” APD and an “implementation” APD into one template. This template only applies to the NCCI.

To ensure that you have all required content for submission of this APD, please contact your CMS Regional Office.

A State should submit an APD to its CMS Regional Office with a cover letter signed by the appropriate State official who is authorized to commit State financial and other resources.

Part I of this APD template is to be used by a State to request CMS approval of Federal financial participation (FFP) for its expenditures for planning and implementing the Medicaid NCCI methodologies in its MMIS for the period March 23, 2010, to March 31, 2011.

Part II of this APD template is to be used by a State to request CMS approval of State deactivation of NCCI edits and / or Medically Unlikely Edits (MUEs) in the Medicaid NCCI methodologies for processing Medicaid claims with dates of service on or after April 1, 2011. None of these edits can be deactivated by a State after March 31, 2011, without prior CMS approval. This type of request must be submitted by a State to its CMS Regional Office no later than March 1, 2011, if it wishes to deactivate, or continue to deactivate, NCCI edits or MUEs by April 1, 2011.

If a State wishes to update or change its request after submitting Part I and / or Part II to its CMS Regional Office, the State only needs to submit to its CMS Regional Office an APD Update with the appropriate information and documentation for that Part of the APD.

Part III of the APD describes the information that a State is requested to report to its CMS Regional Office on its implementation of the Medicaid NCCI methodologies. A State is requested to report:

- if it does not pay its Medicaid claims on the basis of Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes;
- the savings that the State has achieved in using the Medicaid NCCI methodologies in processing Medicaid claims each calendar quarter;

- by February 1, 2011, information on the edits that the State has deactivated from October 2010 through January 2011;
- information on the edits that the State has deactivated after March 31, 2011, for the remaining three calendar quarter in 2011; and
- information on other correct coding methodologies and edits that the State has added to its MMIS for each calendar quarter until the end of 2011.

PART I

REQUEST FOR CMS APPROVAL OF FEDERAL FINANCIAL PARTICIPATION (FFP)

PURPOSE OF PART I OF THIS APD

The purpose of Part I of this APD is for a State to request CMS approval of FFP for the design, development, installation, and enhancement of the State's Medicaid Management Information System (MMIS) for incorporation of the Medicaid National Correct Coding Initiative (NCCI) methodologies into the State's MMIS. A State Medicaid agency must submit an APD containing the information described below to its CMS Regional Office to request this approval.

CMS POLICY

Contingent upon the State's submission of the required information and documentation in Part I of this APD, CMS will approve FFP for State expenditures over the time period from March 23, 2010, to March 31, 2011, for the design, development, installation, and enhancement of the State's MMIS for the incorporation of all Medicaid NCCI methodologies into the State's MMIS. March 23, 2010, is the date of the signing of the Affordable Care Act. CMS requires all States to activate all NCCI edits and Medically Unlikely Edits (MUEs) in all five Medicaid NCCI methodologies for processing all Medicaid claims with a date of service on or after April 1, 2011 (with the exception of the deactivation of select edits previously approved by CMS).

The CMS will approve FFP only for past State expenditures since March 23, 2010, for which the State provides documentation of the activities performed for the above purpose that were funded by these expenditures.

SCOPE OF PART I OF THIS APD

The scope of Part I of this APD submitted by a State should include the State's planned and actual / past and future expenditures over the time period from March 23, 2010, to March 31, 2011, for both planning and implementation activities for the design, development, installation, and enhancement of the State's MMIS to incorporate the Medicaid NCCI methodologies into the State's MMIS.

States have flexibility to add edits beyond the NCCI edits. If this is the case, please identify the edits being added and describe the rationale, as this is helpful and useful information. However, State expenditures related to the implementation of edits that are **not NCCI edits must not be included in the State expenditures for which FFP is being requested.**

INFORMATION REQUIRED FOR SUBMISSION OF PART I OF THIS APD

Section I: Executive Summary

The Executive Summary consists of the Purpose of the Advance Planning Document, Background, and Organization.

Section II: Statement of Need and Requirements Analysis

The Statement of Need and Requirements Analysis presents a summary of project needs and objectives, including a summary of the alternatives considered, and a discussion of the anticipated benefits of the proposed approach. This is a statement of the State's needs and requirements for incorporating the Medicaid NCCI methodologies into its MMIS.

The State Medicaid Director Letter for NCCI, and its enclosures, lay out the required objectives and timeframes for States to meet the requirements of the NCCI statute. This section lays out what the State will need to do to meet these requirements and timeframes. This should include what efforts will be necessary and the rationale for those efforts.

Section III: Project Management Plan, Proposed Project Schedule, and Personnel Resource Statement

Project Management Plan

The Project Management Plan should include:

- a detailed description of the nature and scope of activities to be undertaken;
- the method used to accomplish the project, including products and deliverables;
- the project organization;
- procurement tasks and subtasks required to complete this project, project procurement activities, and procurement schedule, if procurement will be needed for this project; and
- State and contractor resource needs.

A table may be provided to lay out the proposed project organization. The table should include the core project team, State Medicaid agency staff, and augmentation / contractor staff. The project director / manager should be identified.

Section IV: Estimated Total Project Cost, Prospective Cost Distribution, and Proposed Project Budget

The Estimated Total Project Cost and Prospective Cost Distribution present the total project cost and the overall request for Federal financial participation (FFP). This would include the total enhanced (90%) FFP and the total of any regular (50%) FFP. It should then give the requested Federal match amount and the State amount. The sum of these two amounts should equal the total project cost.

In addition, Section IV should specify the period over which the FFP will be claimed. This will correspond to the Proposed Project Schedule from Section III. The period of the FFP should cover March 23, 2010, to March 31, 2011. Documentation should be submitted that identifies which NCCI implementation activities were, are being, and will be performed by time period within these dates and the project costs associated with each of the activities by time period.

As specified in Circular A-87, a cost allocation plan must be included that identifies all participants and their associated cost allocation to depict non-Medicaid activities and non-Medicaid FTEs participating in this project, if any.

A table may be provided to lay out the proposed project budget. The table should include:

1. State Staff Costs (90% FFP)
2. Augmentation Staff Costs (90% FFP)
3. Non-Personnel Services Costs (90% FFP)
4. Training Costs (50% FFP) (State Medicaid Manual, Part 11, 11276.11)
5. Other Indirect Costs (50% FFP) (State Medicaid Manual, Part 11, 11276.9)

Please include any anticipated State-only costs.

COMPONENT / RESOURCE	MEDICAID			NON-MEDICAID COSTS	TOTAL COSTS
	COSTS	PERCENT FEDERAL MATCH ¹	FEDERAL MATCH AMOUNT		
State Staff Costs		90%			
Augmentation Staff Costs ²		90%			
Direct Non-Personnel Costs		90%			
Indirect Personnel and Non-Personnel Costs		50%			
Training Costs ³		50%			
Subtotals					
State-Only Costs (if any)		0%	\$0		
Totals					

The total estimated cost of this effort is \$xxx.

The amount of 90 percent FFP requested is \$xxx.

The amount of 50 percent FFP requested is \$xxx.

Section V: Assurances

¹ Refer to Part 11 of the *State Medicaid Manual* for a complete list of reimbursable costs.

² Please see "Contractual Services" in section 11265 of the *State Medicaid Manual*.

³ State expenditures for the "training of personnel directly engaged in the operation of an MMIS" may be eligible for 75 percent FFP. Please discuss this with your CMS Regional Office.

Section V includes procurement activities, monitoring and reporting activities, including access to records, licensing, ownership of software and the safeguarding of information contained within the system.

These assurances are based on automated data processing equipment for mechanical claims processing, outlined in the Code of Federal Regulations (CFR) listed, the appropriate sections of the State Medicaid Manual (SMM).

Please indicate by checking "yes" or "no" whether or not the State will comply with the Code of Federal Regulations (CFR) and the State Medicaid Manual (SMM) citations.

Please provide an explanation for any "No" responses.

Procurement Standards (Competition / Sole Source)

SMM Section 11267 Yes No

45 CFR Part 95.615 Yes No

45 CFR Part 92.36 Yes No

Access to Records

42 CFR Part 433.112(b)(5) – (9) Yes No

45 CFR Part 95.615 Yes No

SMM Section 11267 Yes No

Software & Ownership Rights, Federal Licenses, Information Safeguarding, HIPAA Compliance, and Progress Reports

45 CFR Part 95.617 Yes No

42 CFR Part 431.300 Yes No

45 CFR Part 164 Yes No

PART II

REQUEST FOR CMS APPROVAL OF STATE DEACTIVATION OF EDITS CONTAINED IN THE MEDICAID NCCI METHODOLOGIES AFTER MARCH 31, 2011

PURPOSE OF PART II OF THIS APD

The State Medicaid Director letter, dated September 1, 2010, on the implementation of the NCCI in Medicaid, as required by Section 6507 of the Affordable Care Act, states that all States must incorporate and activate all NCCI edits and MUEs contained in all five Medicaid NCCI methodologies for all Medicaid claims with a date of service on or after April 1, 2011. A State can deactivate NCCI edits and / or MUEs in the Medicaid NCCI methodologies in its MMIS, but can never deactivate the Medicaid NCCI methodologies themselves in its MMIS.⁴ However, after March 31, 2011, a State Medicaid agency can only deactivate, or continue to deactivate, any of the NCCI edits or MUEs in the Medicaid NCCI methodologies in its MMIS after receiving prior approval from CMS.

The purpose of Part II of this APD is for a State Medicaid agency to request approval from CMS to deactivate one or more NCCI edits and / or MUEs in the Medicaid NCCI methodologies in its MMIS. States which do not want to deactivate any edits contained in the Medicaid NCCI methodologies in its MMIS after March 31, 2011, do not have to complete or submit this Part of this APD.

A State must submit this Part of this APD to its CMS Regional Office no later than March 1, 2011, if it wishes to deactivate, or continue to deactivate, NCCI edits and / or MUEs by April 1, 2011. If a State submits this Part of this APD after March 1, 2011, CMS may not approve deactivation of the requested NCCI edits and / or MUEs until after March 31, 2011. If this is the case, then the State must have the requested edits activated as of April 1, 2011, and cannot deactivate the edits unless and until CMS approval is received.

For example, this Part of this APD might be submitted by a State to its CMS Regional Office for the first time after March 1, 2011, in three situations. (1) A State may not have identified any NCCI edits or MUEs that conflict with State law, regulations, administrative rules, or payment policies until after March 1, 2011. (2) A new quarterly release of the Medicaid NCCI methodology files may contain new or revised NCCI edits or MUEs that now conflict with State law, regulations, administrative rules, or payment policies. (3) A new State law, regulation, administrative rule, or payment policy enacted after March 1, 2011, might conflict with one or more NCCI edits and / or MUEs in the Medicaid NCCI methodologies.

⁴ As stated in the State Medicaid Director letter on the NCCI (SMD #10-017, ACA #7), dated September 1, 2010, NCCI edits and MUEs are only one of four components of the NCCI methodologies. The other three components are definitions of the types of claims subject to the edits, a set of claims adjudication rules for applying the edits, and a set of rules for addressing provider / supplier appeals of denied payments for services based on the edits.

If a State which has received prior CMS approval for deactivation of one or more edits contained in the Medicaid NCCI methodologies after March 31, 2011, subsequently wishes to request CMS approval to deactivate additional edits contained in the Medicaid NCCI methodologies in its MMIS, the State only needs to submit an APD Update to its CMS Regional Office to request this approval. The APD Update should identify the additional edits that the State wants to deactivate, describe the rationale for doing so, and include supporting documentation.

CMS POLICY

The CMS may grant State flexibility to deactivate an NCCI edit or MUE which conflicts with a State law, regulation, administrative rule, or payment policy. CMS will not approve State deactivation of an NCCI edit or MUE after March 31, 2011, because the State is not operationally ready to implement the edit.

For those edits that CMS approves for deactivation by a State after March 31, 2011, CMS will provide the “deletion date” for those edits. The State must add the deletion date to the deletion date field in the NCCI methodology edit files for each of the edits approved for deactivation for each calendar quarter beginning with the calendar quarter in which the edit is first deactivated and every calendar quarter thereafter. The new Medicaid NCCI methodology files for each quarter are complete replacements of prior Medicaid NCCI methodology files; they are not files containing only updates of previous files.

Although the Medicaid NCCI methodology files will be updated for each calendar quarter, a State will not need to submit to its CMS Regional Office each calendar quarter an APD update to request CMS approval to continue deactivation of NCCI edits and MUEs that remain in conflict with existing State law, regulations, administrative rules, or payment policies.

However, if the relevant State law, regulation, administrative rule, or payment policy changes, so that it no longer conflicts with the edit(s), then the State is required to reactivate the edit(s) and notify CMS of the changes and reactivation through an APD Update. The APD Update should identify the edit(s) that the State is reactivating, describe the reason or rationale for doing so, and include supporting documentation.

If a State reactivates one or more edits, the “effective date” for each of the reactivated edits must be the first day of the calendar quarter in which the edit is active for claims processing. The State must modify the “effective date” in the State’s Medicaid NCCI methodology edit files for each reactivated edit to reflect the new “effective date”. Since the quarterly Medicaid NCCI methodology files are replacement files, rather than update files, the State must modify the effective date for each reactivated edit each quarter subsequent to the reactivation.

A State Medicaid agency cannot change or modify an activated edit contained in the Medicaid NCCI methodologies. The edits in the Medicaid NCCI methodologies are specific to the NCCI. Consequently, CMS is not providing State flexibility to modify NCCI edits or MUEs. However,

CMS has authorized State flexibility to incorporate a changed or modified edit into its MMIS outside of the Medicaid NCCI methodologies.

Specifically, if a State wishes to change or modify an edit, the State should submit this Part of this APD to request CMS approval for deactivation of this edit in the Medicaid NCCI methodologies after March 31, 2011. If CMS approves deactivation of the edit, the State should deactivate the edit within its Medicaid NCCI methodologies and incorporate into its MMIS the edit in the changed or modified form that it wishes to use instead. The changed or modified edit will not be part of the Medicaid NCCI methodologies. States can use edits other than those contained in the Medicaid NCCI methodologies, but they cannot deactivate any of the edits contained in the Medicaid NCCI methodologies after March 31, 2011, without prior CMS approval.

INFORMATION REQUIRED FOR SUBMISSION OF PART II OF THIS APD

For each edit, or group of edits, in the Medicaid NCCI methodologies that a State requests CMS approval to deactivate after March 31, 2011, please provide to the State's CMS Regional Office the information listed below:

- Specify the edit file by provider category that the edit is contained in:
 - practitioner / ambulatory surgery center;
 - outpatient hospital; or
 - durable medical equipment.
- Specify the type of edit it is: NCCI or MUE.
- For NCCI edits:
 - list each edit in terms of its "column one / column two" code;
 - provide the long (not the short) code descriptor for each code;
 - provide the modifier indicator for the edit; and
 - provide the effective date for the edit.
- For MUEs:
 - list each edit by its code number and
 - provide its current MUE value.
- If a State wants to deactivate an edit because it conflicts with a State law, regulation, administrative rule, or payment policy, please:
 - specify and describe the State law, regulation, administrative rule, or payment policy the edit conflicts with;
 - specify and describe what the conflict is; and

- provide a copy of the State law, regulation, administrative rule, or payment policy that the edit conflicts with.

- In the case of a new State law, regulation, administrative rule, or payment policy that an edit conflicts with, please also include the date that the new State law, regulation, administrative rule, or payment policy goes into effect.
- Consistent with the information above, if a State wants to deactivate an edit and subsequently change or modify the edit outside of the Medicaid NCCI methodologies, please describe the change or modification of the edit that the State wants to make and the reason for the change or modification.
- If the State wants to deactivate the edit for another reason, please specify the reason, describe the rationale for deactivation, and provide any supporting documentation. CMS will assess the reason and rationale given for the proposed deactivation, but there is no guarantee that CMS will approve deactivation of the edit for the reason and rationale given.

A State can provide the above information (e.g., in a spreadsheet) as an attachment to Part II of this APD that it submits to its CMS Regional Office.

PART III

REPORTING REQUIREMENTS ON STATE IMPLEMENTATION OF THE NCCI IN MEDICAID

REIMBURSEMENT OF STATE MEDICAID CLAIMS NOT BASED ON HCPCS AND CPT CODES

The NCCI edits and MUEs contained in the NCCI methodologies are based on the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, some States do not reimburse their Medicaid claims on the basis of HCPCS and CPT codes. For example, some States reimburse their Medicaid claims on the basis of “revenue code”. A State that does not reimburse its Medicaid claims on the basis of HCPCS or CPT codes is required to report to its CMS Regional Office the basis that it uses (e.g., “revenue code”) to reimburse its Medicaid claims.

SAVINGS DUE TO IMPLEMENTATION OF THE NCCI IN THE STATE’S MEDICAID PROGRAM

Each State is required to report to its CMS Regional Office for each calendar quarter until the end of calendar year 2011, the savings in Medicaid claims payments that the State achieved as a result of using the Medicaid NCCI methodologies in processing its Medicaid claims.

STATE DEACTIVATION OF EDITS

A State which has deactivated edits before February 1, 2011, is required to report to its CMS Regional Office by February 1, 2011, the following information for the period October 1, 2010, to January 31, 2011:

- the number edits that were deactivated;
- the types of edits that were deactivated;
- the rationale for deactivating the edits;
- the process and the workload for State staff that deactivating edits created;
- the number and dollar amount of claims that would have been denied, if the edits were not deactivated;

- the number and dollar amount of claims that would have gone to appeal, if the edits were not deactivated;
- the number and dollar amount of claims that were paid as a result of the deactivations;
- the total number of providers that would have had denied claims, if the edits were not deactivated; and
- any additional information that is necessary in order to determine the impact that deactivation of the edits has had on both providers and the State.

This information will be used in CMS' report to Congress on March 1, 2011.

A State which receives CMS approval for deactivating Medicaid NCCI / MUE edits after March 31, 2011, must report the same information to its CMS Regional Office for each calendar quarter until the end of calendar year 2011.

ADDITIONAL CORRECT CODING METHODOLOGIES AND EDITS INCORPORATED INTO A STATE'S MMIS

The CMS encourages States to develop and incorporate additional correct coding methodologies and edits that go beyond those contained in the Medicaid NCCI methodologies to promote correct coding and to control improper coding leading to inappropriate payment of Medicaid claims. For example, a State may want to extend Medicaid NCCI methodologies to claims for additional types of services (e.g., managed care) and claims from additional sites of services (e.g., long-term care facilities, Critical Access Hospitals (CAHs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), etc.).

If a State's Medicaid managed care program uses managed care organizations (MCOs), then the Medicaid NCCI methodologies generally would not apply to the extent that the MCOs generate no claims for Medicaid reimbursement. However, if a State's Medicaid managed care program uses Primary Care Case Management (PCCM), in which the provider receives a small capitation fee, but bills the State's Medicaid program for services provided, then the Medicaid NCCI methodologies would be applied to those claims.

A State may incorporate additional correct coding methodologies and / or edits into its MMIS that go beyond the Medicaid NCCI methodologies and edits without prior CMS approval. However, if it does so, these additional correct coding methodologies and edits will not be part of the Medicaid NCCI methodologies. If a State believes that these additional correct coding methodologies or edits should be part of the national Medicaid NCCI methodologies, the State should submit its rationale to CMS' technical contractor for the NCCI, Correct Coding Solutions, LLC, for review by the CMS Medicaid NCCI Workgroup.

The CMS requests that a State which incorporates additional correct coding methodologies and / or edits into its MMIS that go beyond the Medicaid NCCI methodologies and edits report to its

CMS Regional Office what these additional correct coding methodologies and edits are and the reason or rationale for adding them to its MMIS.

A State's MMIS may contain edits for processing Medicaid claims from a variety of sources, e.g., the Medicaid NCCI methodologies, additional State-specific correct coding methodologies and edits, edits from commercial off-the-shelf (COTS) software used by the State to process Medicaid claims, and edits from the vendor the State contracts with to process Medicaid claims. Denials for payments of Medicaid claims that are due to edits from these other sources that are not contained in the Medicaid NCCI methodologies should not be attributed to the Medicaid NCCI methodologies.

A State which has incorporated additional correct coding methodologies and edits into its MMIS is required to report to its CMS Regional Office for each calendar quarter until the end of calendar year 2011 the following information:

- a description of the additional correct coding methodologies and edits the State has incorporated into its MMIS and
- the savings in Medicaid claims payments that the State achieved as a result of using the additional correct coding methodologies and edits in processing its Medicaid claims.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 28 Jul 2011 07:58:22 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan)';Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov)';Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Update on Delivery System Reforms Now Available on
Healthcare.gov
Attachments: Fact Sheet on Healthcare.gov_deliverysystemreform final.pdf

U.S. House and Senate Notification
Wednesday, July 27, 2011

To: Congressional Health Staff

From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Update on Delivery System Reforms Now Available on Healthcare.gov

Today, a new fact sheet was posted to the healthcare.gov website that provides an update on implementation of some of the key reforms, many of which were included in the Affordable Care Act, to the health care delivery system.

The Affordable Care Act makes an historic investment in tools to help transform our health care delivery system over the long run—tools that will reduce and eliminate preventable injuries to patients, reward quality and innovation, and spur adoption of technology that improves care while better aligning payment incentives to reward providers who work to improve care.

The long-term savings from these reforms are not yet fully realized, but they are setting the stage for a transformation of the way that health care is delivered in the United States, to put us on a path toward a patient-centered system that rewards the quality of care delivered, not just the quantity of services provided.

Some examples of HHS ongoing implementation of these reforms include:

- The Partnership for Patients—a public/private initiative that seeks to significantly reduce preventable injuries and complications in patient care and to reduce avoidable hospital readmissions;
- Hospital Value-based Purchasing, which links a portion of hospitals' payments to the quality of care they furnish; and
- Increased efforts to fight healthcare fraud with a \$350 million investment from the Affordable Care Act.

More details about these delivery system reforms are available in the attached factsheet and on healthcare.gov at: <http://www.healthcare.gov/news/factsheets/deliverysystem07272011a.html#>

If you have any questions, please contact the CMS Office of Legislation. Thank you.

Better Health, Better Care, Lower Costs: Reforming Health Care Delivery

As our nation works to bring health care costs under control, much of the focus is on how to make changes to our health care system that will improve the quality and safety of care and provide measureable savings in the coming decade. The Affordable Care Act makes an historic investment in tools to help transform our health care delivery system over the long run—tools that will reduce and eliminate preventable injuries to patients, reward quality and innovation, and spur adoption of technology that improves care while better aligning payment incentives to reward providers who work to improve care.

The long-term savings from these reforms are not yet being fully realized, but they are setting the stage for a transformation of the way that health care is delivered in the United States, to put us on a path toward a patient-centered system that rewards the quality of care delivered, not just the quantity of services provided.

This fact sheet provides an update on implementations of some of the key reforms to our health care delivery system, through July 27, 2011.

PAYING FOR PERFORMANCE:

- **Hospitals.** The first large-scale Hospital Value-Based Purchasing Program—which will pay over 3,500 hospitals nationwide according to whether they meet performance standards and how much they improve—takes effect for hospitalizations on October 1, 2012. CMS also would strengthen its current pay-for-reporting program for hospital outpatient departments and—for the first time— extend pay-for-reporting to the ambulatory surgery center setting in 2014, as part of a July proposed payment rule. Data collection would begin as early as 2012.
- **Physicians.** CMS has proposed to continue to strengthen the Physician Quality Reporting System through the 2012 Physician Fee Schedule as part of CMS’ broader strategy to encourage health care providers to adopt practices that can improve patient care by providing physicians with incentives to voluntarily report quality measurement data to the Agency.
- **Medicare Advantage Plans.** CMS strengthened the Affordable Care Act’s “five-star” plan bonus system to accelerate and increase the incentives for improvement in the quality of care provided to nearly 12 million beneficiaries.
- **Dialysis Facilities.** A new End-Stage Renal Disease (ESRD) Quality Incentive Program will, for the first time, tie CMS payments directly to facility performance on quality measures, resulting in better care at a lower cost for nearly 500,000 enrollees with ESRD.
- **Home Health Agencies.** More than 100 Home Health Agencies that are part of the two-year Medicare Home Health Pay for Performance demonstration are getting nearly \$15 million in shared savings from providing better care at lower cost.

PROMOTING BETTER CARE AND PROTECTING PATIENT SAFETY:

- **Partnership for Patients.** This nationwide initiative will help save 60,000 lives by stopping millions of preventable injuries and complications in patient care over the next three years. Over the next ten years, the Partnership for Patients could reduce costs to Medicare by about \$50 billion and result in billions more in Medicaid and private sector savings. The Partnership was announced on April 12, and since then more than 4,500 organizations—including physician and nurses’ organizations, consumer groups, employers and over 2,000 hospitals—have pledged to help achieve the Partnership’s goals of reducing hospital complications and improving care transitions.

As part of the Partnership for Patients, CMS is soliciting applications for a new \$500 million Community-Based Care Transitions Demonstration that would support partnerships between hospitals with high rates of readmissions and community-based organizations to help patients make more successful transitions from hospital to home or to another post-hospital setting.

The CMS Innovation Center has also posted a request for bids for state, regional, national, or hospital system organizations to spread best practices that have already been proven to prevent infections in hospitals.

- **Accountable Care Organizations.** Through the creation of voluntary Accountable Care Organizations (ACOs), health care providers can more easily work together to coordinate care for an individual patient across care settings—including doctors’ offices, hospitals, and long-term care facilities. Medicare will reward ACOs that meet quality performance standards and lower growth in health care costs. By putting patients first, the ACO initiative is estimated to generate \$510 million in Medicare savings over three years.
- **Expanding Electronic Health Records (EHR).** Adoption of electronic health records will make it easier for physicians, hospitals, and others serving Medicare beneficiaries to assess a patient’s medical status and make sure that care is appropriate. They will also help eliminate redundant and costly procedures. Since registration for the EHR incentive programs opened on January 3, 2011, more than 68,000 eligible providers have registered and more than \$273.2 million in incentives has been awarded.
- **Quality Improvement Organization (QIO) Program.** The national QIO network comprises organizations operating in each state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, whose mission is to spread rapid, large-scale, health-system change. Under a new multi-year contract, QIOs will become key drivers of Affordable Care Act reforms, working with patients, providers, and practitioners across all health care settings and cultural and geographic boundaries to reconfigure the current delivery system into patient-centered care.

ENSURING ALL AMERICANS GET THE RIGHT CARE WHEN THEY NEED IT:

- **Saving Lives by Focusing on Prevention.** Harmful, costly disease can be prevented – or caught at the earliest, most treatable stages – by making sure more Americans get the routine services they need, when they need them. As a result of the Affordable Care Act, millions of

seniors have already received free prevention services from their doctor, including millions of annual wellness visits this year alone.

- **Improving Access to Primary Care Doctors and Surgeons.** The Affordable Care Act gives most primary care physicians a 10 percent incentive payment for commonly-performed services, such as office visits, performed on or after January 1, 2011. It also gives general surgeons in rural and other shortage areas a 10 percent bonus for performing certain types of surgeries. The projected increases in 2011 from the incentives are \$240 million for primary care providers and \$10 million for surgeons in shortage areas.
- **Coordinating Care for Patients with Medicare and Medicaid.** Fifteen states are receiving \$1 million each in new federal funding to develop better ways to coordinate care for people with both Medicare and Medicaid, who often have more complex and costly health care needs. Strategies include more flexibility for home and community-based services and improving health IT systems.

Two new grant programs are currently taking states' applications to test the best ways to pay for care integration for dually-eligible beneficiaries and ways to improve nursing home care so they can stay out of the hospital. CMS is also establishing a technical resource center focusing exclusively on improving care for these high-need, high cost beneficiaries.

- **Ensuring Greater Independence for Americans with Disabilities.** CMS will distribute over \$45 million in grants to states in 2011, and more than \$621 million through 2016 to build Medicaid long-term care programs that will help keep people at home and out of institutions.

CRACKING DOWN ON FRAUD AND WASTE:

- **Lowering the Cost of Health Care Equipment and Supplies.** A stronger competitive bidding program sets new, lower payment rates for medical equipment and supplies. CMS estimates that Medicare and beneficiaries will pay 35 percent less on average for equipment and supplies. The program is expected to save Medicare and its beneficiaries approximately \$30 billion over 10 years.
- **Avoiding Unnecessary Radiation Exposure for Patients.** A new Affordable Care Act demonstration is testing whether using decision support systems can promote appropriate use of imaging technology, to reduce unnecessary radiation exposure and utilization.
- **Fighting Fraud.** The Affordable Care Act takes landmark steps forward and invests \$350 million to improve and enhance the Administration's ongoing efforts to prevent and detect fraud, and crack down on individuals who attempt to defraud Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) as well as private insurance, including:
 - **Tough New Rules and Sentences for Criminals:** The Affordable Care Act increases the federal sentencing guidelines for health care fraud offenses by 20-50% for crimes that involve more than \$1 million in losses. The law establishes penalties for obstructing a

- fraud investigation and makes it easier for the government to recapture any funds acquired through fraudulent practices.
- **Cutting-Edge Technology:** Starting July 1, CMS began using innovative predictive modeling technology to fight Medicare fraud. Similar to technology used by credit card companies, predictive modeling helps identify potentially fraudulent Medicare claims on a nationwide basis, and help stop fraudulent claims before they are paid.
 - **Enhanced Screening and Other Enrollment Requirements:** New enrollment requirements for all Medicare, Medicaid, and CHIP providers and suppliers require some categories of providers and suppliers who have historically posed a higher risk of fraud or abuse to be screened before enrolling in the Medicare or Medicaid programs or CHIP, and allow the Secretary and CMS to take other steps to suspend payments or provider and supplier enrollment if fraud is suspected. This will move Medicare away from a “pay and chase” mode of having to track down fraudulent payments after the fact.
 - **Increased Coordination of Fraud Prevention Efforts:** Many of the Affordable Care Act provisions increase coordination between states, CMS, and its law enforcement partners at OIG and DOJ. The law ensures that fraudulent providers and suppliers cannot move from state to state or between Medicare and Medicaid by requiring all states to terminate anyone who has been terminated by Medicare or by another state.
 - **Sharing Data to Fight Fraud:** Building on the Obama Administration initiatives to improve coordination across the agencies charged with stopping fraud, the law requires certain claims data to be centralized, making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis.
 - **New Tools to Target High Risk Entities:** The Affordable Care Act strengthens the government’s authority to require certain high-risk providers and suppliers to undergo a higher level of scrutiny before enrolling in the program based on the risk of fraud, waste, or abuse they pose to the program.

For a full list of new Affordable Care Act tools to fight fraud, visit www.HealthCare.gov/news/factsheets/fraud03152011a.html.

- **Reducing the Deficit.** The Congressional Budget Office estimated that the Affordable Care Act would reduce the deficit by \$143 billion over its first 10 years, while the Medicare Trustees Report for 2010 projected that the new law would extend the life of the Medicare Trust Fund by 12 years, from 2017 to 2029.

HELPING AMERICANS TAKE CONTROL OF THEIR HEALTH:

- **Beneficiaries get Written Notice of their Right to Quality Care.** Under a proposed rule, issued February 2, 2011, most providers and suppliers would need to inform beneficiaries of their rights to contact state survey agencies and to complain about health-care quality to one

of Medicare's Quality Improvement Organizations. Currently only beneficiaries who are hospital inpatients get information about QIOs.

- **Hospital-acquired Conditions.** Now—along with other data that's available on Hospital Compare—beneficiaries can find information on the incidence of serious Hospital-Acquired Conditions (HACs) in individual hospitals. In FY 2015, hospitals with high rates of HACs will see their payments reduced.
- **Access to Quality Information.** Qualified organizations would have access to Medicare performance reports on hospitals, physicians, and other health care providers, helping consumers and employers make better health care decisions, promoting competition and driving down costs, under a proposed regulation issued in June.

DEVELOPING MEASURES OF HEALTH CARE QUALITY:

- **Hospitals.** The recent proposed rule for acute care hospital inpatient payment includes proposed measures for the new Readmissions Reduction Program required by the Affordable Care Act and proposes new measures for hospital quality reporting.
- **Inpatient Rehabilitation Facilities.** Under a proposed rule, IRFs would report in 2012 on two of the nine conditions that are included in the Partnership for Patients initiative, and a third measure under development would address readmissions within 30 days.
- **Hospices.** As part of Medicare's 2012 hospice wage index regulation, hospices would begin reporting on quality measures—including a measure on pain management—or face a two percent reduction in their inflation update if they did not submit their reports in 2013.

OTHER SYSTEM-WIDE REFORMS GOING ON NOW:

- **System-wide Quality Improvement.** Critical reforms already underway include reducing adverse drug events and reducing bed sores in nursing homes; improving cardiac care and outcomes; reducing health disparities; and emphasizing to providers the importance of engaging patients in decisions about their care.
- **Physician Quality Reporting and ePrescribing.** Nearly 120,000 physicians and other eligible professionals in nearly 12,650 practices reported quality-related data satisfactorily in 2009 through the Physician Quality Reporting System. They received incentive payments totaling more than \$234 million. CMS paid \$148 million to 48,354 physicians and other eligible professionals under the e-Prescribing Incentive Program in 2009 to promote the adoption of ePrescribing to reduce medication-related errors and identify options for treatment that can lower costs to beneficiaries while producing the desired outcomes.
- **New State Authority to Tie Payment to Quality in Medicaid.** Under a new Affordable Care Act regulation, state Medicaid programs can reduce or prohibit payments to doctors, hospitals and other health care providers for services that result from certain preventable healthcare acquired illnesses or injuries, just as Medicare is able to do.

- **Medicare and Medicaid Innovation Center.** The Innovation Center is charged with identifying, testing and ultimately spreading new ways of delivering and paying for care. The new center, which opened its doors on November 17, 2010, is authorized to invest up to \$10 billion in initiatives that will have a high “return on investment,” more than paying for itself according to the Congressional Budget Office.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Feb 2011 17:03:53 -0500
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Brooks, Mo (seibenhener, lance);Newton, Andrew (Sessions);'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Rogers, Mike (hunter.walton@mail.house.gov);Sewell, Terri (Abney, Allison);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams@mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Garrett Bess);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chambliss, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Gingery, Phil (RobertHorne@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Jack Kingston (Allison.Thigpen@mail.house.gov);Johnson, Hank (scott.goldstein@mail.house.gov);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (jasmine.weatherby@mail.house.gov);'McConnell, Mitch';O'Brien, Lauren;Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Palazzo, Steven (Spencer Wayne);Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (susan_sweat@wicker.senate.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);Burr, Richard (Jennifer_Nardi@help.senate.gov);Butterfield, G.K. (Ken.Willis@mail.house.gov);'Coble, Howard';Elmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair);Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Skouras, Spyros);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Jim DeMint (matt_hoskins@demint.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Alexander, Lamar (Lapinski, MarySumpter (HELP Committee));Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Phil Roe;Swager, Curtis (Alexander)

Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: Update on Implementation of the DMEPOS Competitive Bidding Program
Attachments: Press Release DMEPOS 2.16.11.pdf

U.S. House and Senate Notification
Wednesday, February 16, 2011

To: Congressional Health Staff

From: Amy Hall, Director, Office of Legislation
Centers for Medicare & Medicaid

Re: Update on Implementation of the DMEPOS Competitive Bidding Program

On January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) launched the first phase of Medicare's competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in nine different areas of the country. Through the use of supplier competition, the program set new, lower payment rates for certain medical equipment, such as oxygen equipment and certain power wheelchairs. As a result, more than four million Medicare beneficiaries living in the nine competitive bidding areas will save money, while continuing to have access to quality medical equipment from accredited suppliers they can trust. CMS estimates that beneficiaries and the Medicare program will pay 32 percent less on average for these equipment and supplies.

We are pleased to report that implementation of the program is going very smoothly. We continue to deploy a wide array of resources across all of the competitive bidding areas to address any concerns that may arise. These resources include local State Health Insurance and Assistance Program (SHIP) offices, specially trained customer service representatives at 1-800-MEDICARE, and caseworkers in Medicare's regional offices who all stand ready to assist beneficiaries who may have questions about the program. In addition, there is a complaint and inquiry process for beneficiaries, caregivers, doctors, referral agents and suppliers to use for reporting concerns about a contract supplier or other competitive bidding implementation issues. This process is designed to ensure that all complaints are correctly routed, investigated, resolved, tracked and reported. Further, there is a Competitive Acquisition Ombudsman who will respond to complaints and inquiries from suppliers and others about the application of the program and issue an annual Report to Congress.

Since the beginning of the program, we have only received a handful of beneficiary complaints and have acted quickly to resolve each one. While 1-800 MEDICARE has received a number of inquiries about the program, the majority of such inquiries are on routine matters, such as selecting a supplier. We urge all stakeholders to bring any issues to our attention in order for our caseworkers to resolve them as quickly as possible.

The CMS press release is attached. If you have any questions about this implementation update or the DMEPOS competitive bidding program generally, please contact the CMS Office of Legislation at 202-690-8220.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201



Office of Media Affairs

MEDICARE NEWS/FACT SHEET

FOR IMMEDIATE RELEASE
February 16, 2011

Contact: CMS Office of Media Affairs
(202) 690-6145

New medical equipment program offers value for Medicare beneficiaries

Competitive bidding program focuses on providing access to high quality products and services for people with Medicare

The Centers for Medicare & Medicaid Services (CMS) launched the first phase of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program on January 1, 2011, in nine different areas of the country.

Through supplier competition, the program set new, lower payment rates for certain medical equipment and supplies, such as oxygen equipment, certain power wheelchairs and mail order diabetic supplies. CMS estimates that Medicare and beneficiaries will pay 32 percent less on average for these equipment and supplies. In most cases, Medicare beneficiaries who obtain these items in the nine competitive bidding areas will need to get them from the Medicare suppliers that were awarded contracts in order to have the items covered under Medicare. More than four million Medicare beneficiaries living in the nine competitive bidding areas can save money through this new program, while continuing to have access to quality medical equipment from accredited suppliers they can trust.

“We are pleased to report that implementation of the program is going very smoothly,” said CMS Administrator Donald Berwick, M.D. “We continue to deploy a wide array of resources across all of the competitive bidding areas to address any concerns that may arise.”

These resources include local State Health Insurance and Assistance Program (SHIP) offices, specially trained customer service representatives at 1-800-MEDICARE, and caseworkers in Medicare’s regional offices who all stand ready to assist beneficiaries who may have questions about the program. In addition, there is a complaint and inquiry process for beneficiaries, caregivers, doctors, referral agents and suppliers to use for reporting concerns about a contract supplier or other competitive bidding implementation issues. This process is

-More-

designed to ensure that all complaints are correctly routed, investigated, resolved, tracked and reported. Further, there is a Competitive Acquisition Ombudsman who will respond to complaints and inquiries from suppliers and others about the application of the program and issue an annual Report to Congress.

Since the beginning of the program, CMS has received only a handful of beneficiary complaints and has acted quickly to resolve each one. While 1-800 MEDICARE has received a number of inquiries about the program, the majority of such inquiries are on routine matters, such as selecting a supplier.

“CMS continues to monitor the implementation of the program very carefully” said Dr. Berwick. “We urge all stakeholders to bring any issues to our attention in order for our caseworkers to resolve them as quickly as possible.”

Program monitoring includes the use of beneficiary surveys, active claims surveillance and analysis, contract supplier reporting, and tracking and analysis of complaints and inquiries in the nine initial areas, which include Charlotte, Cincinnati, Cleveland, Dallas, Kansas City, Miami, Orlando, Pittsburgh and Riverside. CMS has taken administrative actions against a small number of contract suppliers to help bring them back into compliance with Medicare’s rules.

Only the following categories of items are included in the first phase of this program:

- Oxygen, Oxygen Equipment, and Supplies
- Standard Power Wheelchairs, Scooters, and Related Accessories
- Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2 only)
- Mail-Order Diabetic Supplies
- Enteral Nutrients, Equipment and Supplies
- Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices (RADs), and Related Supplies and Accessories
- Hospital Beds and Related Accessories
- Walkers and Related Accessories
- Support Surfaces (Group 2 mattresses and overlays in Miami-Ft. Lauderdale-Pompano Beach, FL only)

The Medicare DMEPOS Competitive Bidding Program was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the program was briefly implemented in 2008 in 10 areas before it was temporarily delayed. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, terminated the supplier contracts in effect at the time, temporarily delayed the program, and made certain limited changes to the program. MIPPA also required CMS to conduct the

competition again for Round One in 2009, and delayed competition for Round Two in 70 additional metropolitan statistical areas (MSAs) until 2011 and in additional areas of the country until after 2011. The Affordable Care Act of 2010 expands the number of Round Two MSAs from 70 to 91 areas.

Read more about how the Affordable Care Act improves Medicare at <http://www.healthcare.gov/>

For additional information about the Medicare DMEPOS Competitive Bidding Program, please visit: <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/>.

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 29 Apr 2013 16:35:49 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);Hunt, Lauren (CMS/CQISO);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Hankey, Mary Blanche (Sessions);Martha Roby (aubrey.waldock@mail.house.gov);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Terri Sewell (rob.nesmith@mail.house.gov);Young, M.V. (Shelby) <M.V._Young@shelby.senate.gov>;Abby.Dosoretz@mail.house.gov;Albohm, Sasha (Bill Nelson) (Sasha_Albohm@billnelson.senate.gov);Alcee Hastings (Christian.Sy@mail.house.gov);Bilirakis, Gus;Bill Nelson (Rachel Pryor);Brown, Corrine;Brown, Elizabeth;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);Deutch, Ted (Richard, Joel);Diaz-Balart, Mario;Frankel, Lois (Jim Cho);Garcia, Joe (David Montes);Grayson, Alan (Juan Lopez);Grayson, Alan (Julie Tegen);John Mica (Casey.Brinck@mail.house.gov);Kerry Allen (Bill Nelson);Miller, Jeff (diane.cihota@mail.house.gov);Murphy, Patrick (Fisher, Christopher);Nelson, Bill (Oliver Kim);Nugent, Richard (Katherine Troller);Posey, Bill;Rooney, Tom (jessica.moore@mail.house.gov);Ros-Lehtinen, Ileana <Nathan.Gately@mail.house.gov>;Ross, Dennis (melissa.gierach@mail.house.gov);Rubio, Marco (Sally Canfield);Simon, David (Brown, Corine);PSC Karen.williams@mail.house.gov;Ted Yoho (Larry Calhoun);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);Wilson, Frederica (keenan.austin@mail.house.gov);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Butler, Bo (Chambliss) <Bo_Butler@chambliss.senate.gov>;Collins, Doug (Jennifer Lackey);David Scott (lauren.lattany@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Grays, Tom (jason.murphy2@mail.house.gov);Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov);Isakson, Johnny (Pastor, Francie);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Allison Thigpen);Lewis, John (Thomas Dorney);Paul Broun (joe.murray@mail.house.gov);Phil Gingrey (David Pulliam);'Price, Tom';'Price, Tom (Emily Henehan)';Price, Tom (Natalie.Burkhalter@mail.house.gov);Scott, Austin (Jessica Robertson);Westmoreland, Lynn (Stephanie Newton);Woodall, Rob (Janet Rossi);Andy Barr (David Stern) (david.stern@mail.house.gov);Conklin, Jennifer (McConnell);Katelyn Conner;Massie, Thomas (Seana Cranston);'McConnell, Mitch';Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);sarah_arbes@mcconnell.senate.gov;Whitfield, Ed (Booth, Taylor <Taylor.Booth@mail.house.gov>);Yarmuth, John (Jessica Phelps);Adam Buckalew;Allred, SarahLloyd (Wicker);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);Stone, Sarah (Cochran) Sarah_Stone@cochran.senate.gov;'Thompson, Bennie';Thompson, Bennie (Jenkins, Lemia);Thompson, Bennie (TSMITH@mail.house.gov);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Burr, Richard (Andrea_Davis@burr.senate.gov);Butterfield, G.K. (Hernandez, Saul <Saul.Hernandez@mail.house.gov>);Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Holding, George (Ryan Hart);Howard Coble (meredith.downen@mail.house.gov);Hudson, Richard (Michael Thornberry);Jones, Walter (joshua.bowlen@mail.house.gov);Mark Meadows (Allison Witt) (allison.witt@mail.house.gov);'McHenry, Patrick';'McIntyre, Mike (Milligan, Blair)';Pittenger, Robert (Michelle Jelnicky);Price, David;Teitelbaum, Joshua (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Stringer, Meghan);Wade, Karen (Hagan);'Watt, Melvin';Alexander, Lamar (Alicia_Hennie@help.senate.gov);Andreae, Taylor (L. Graham);'Clyburn,

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Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Hill Notification: CMS Issues Hospice FY 2014 Medicare Payment Rates and the Wage Index Proposed Rule
Attachments: Hospice FY 2014 NPRM FS.PDF

**U.S. House and Senate Notification
Monday, April 29, 2013**

To: Congressional Health Staff

**From: Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: CMS Issues Hospice FY 2014 Medicare Payment Rates and the Wage Index Proposed Rule

Today, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule addressing hospice payment rates and the wage index for fiscal year (FY) 2014. The proposed rule would increase Medicare payments to hospices by an estimated 1.1 percent for FY 2014, amend hospice quality reporting requirements, clarify coding requirements, and update stakeholders on hospice payment reform.

As proposed, hospices would see an estimated 1.1 percent (\$180 million) increase in their payments for FY 2014, a net result of a proposed hospice payment update to the hospice per diem rates of 1.8 percent (a "hospital market basket" increase of 2.5 percent minus 0.7 percentage point for reductions mandated by the Affordable Care Act), and a 0.7 percent decrease in payments to hospices due to updated wage data and the fifth year of CMS' seven-year phase-out of its wage index budget neutrality adjustment factor.

The proposed rule can be downloaded from the Federal Register at: <http://ofr.gov/inspection.aspx>. CMS will accept comments on the proposed rule until June 28, 2013. More details about this proposed rule are included in the attached fact sheet.

If you have any questions about this announcement, please contact the Office of Legislation. Thank you.



FACT SHEET

FOR IMMEDIATE RELEASE
April 29, 2013

Contact: CMS Media Relations
(202) 690-6145

CMS PROPOSES UPDATES TO THE WAGE INDEX AND PAYMENT RATES FOR THE MEDICARE HOSPICE BENEFIT

On April 29, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule [CMS-1449-P] that would update fiscal year (FY) 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries.

The proposed hospice payment rule reflects the ongoing efforts of CMS to support beneficiary access to hospice. As proposed, hospices would see an estimated 1.1 percent (\$180 million) increase in their payments for fiscal year (FY) 2014. The hospice payment increase would be the net result of a proposed hospice payment update to the hospice per diem rates of 1.8 percent (a “hospital market basket” increase of 2.5 percent minus 0.7 percentage point for reductions mandated by law), and a 0.7 percent decrease in payments to hospices due to updated wage data and the fifth year of CMS’ seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). The rule proposes that CMS would update the hospice per diem rates for FY 2014 and subsequent years through the annual hospice rule or notice, rather than solely through a Change Request, as has been done in prior years.

Proposed Rule Details

BNAF phase-out. This proposed rule would implement the fifth year of the seven-year BNAF phase-out, reducing the BNAF by 15 percent, for a total reduction of 70 percent since FY 2010. The BNAF was implemented in 1997, when the former Health Care Financing Administration (HCFA), now CMS, moved from an outdated wage index to a more current and accurate method for determining hospice payments. In the FY 2010 Hospice Wage Index final rule, CMS finalized a schedule to phase-out the BNAF over seven years, reducing it by 10 percent in FY 2010 and by 15 percent reductions each year from FY 2011 through FY 2016.

Coding clarification. The proposed rule solicits comments with the intent of clarifying appropriate diagnosis coding in hospice claims.

Longstanding policy requires that hospices adhere to ICD-9-CM coding guidelines. CMS clarifies that hospice providers should not use certain non-specific diagnoses or diagnoses that,

under coding guidelines, are not principal diagnoses; instead, hospices should code the principal diagnosis using the underlying condition that is the main focus of the patient's care. CMS is interested in gaining a better understanding of those who are served by the Medicare hospice program.

Hospice quality reporting. Under section 3004 of the Affordable Care Act, hospices that fail to meet quality reporting requirements will receive a two percentage point reduction to their market basket update beginning in FY 2014. Hospices began reporting quality data in 2013. For the FY 2014 payment determination, hospices reported two measures: the NQF #0209/Pain Management measure and the Structural measure on participation in a /Quality Assessment and Performance Improvement (QAPI) program. The proposed rule solicits comments on the elimination of these two currently reported quality measures beginning with the 2016 payment determination and to replace these two with other measures.

For the FY 2016 payment determination, CMS proposes the implementation of a standardized patient-level data collection instrument called the Hospice Item Set (HIS). The measures in the HIS address multiple important aspects of hospice patient care. Hospices would be required to complete the HIS at admission and discharge on all patients admitted to hospice starting July 1, 2014. HIS data submission would affect the payment determination for FY 2016.

Patient Experience of Care. This proposed rule provides information about CMS's efforts to develop a Hospice Experience of Care Survey for informal caregivers of hospice patients. The rule also proposes to require use of the survey beginning in 2015. The survey would include questions on hospice provider communications with patients and families; hospice provider care, and overall rating of hospice. CMS proposes to include participation in the survey as a quality-reporting requirement for hospices to receive their full annual payment update beginning in FY 2017.

CMS will continue to keep hospices informed of its efforts to develop this experience of care survey, and final requirements would be published in FY 2015 rulemaking.

Other Affordable Care Act reforms. Finally, as mandated in section 3132(a) of the Affordable Care Act, CMS must reform hospice payments no earlier than October 2013 and is authorized to collect additional data that may be used to revise the hospice payment system. In this proposed rule, CMS provides updates on Medicare hospice payment reform efforts, including a discussion of reform model options; highlights from recent reform research; and an update on data collection efforts.

To read the technical report with details on research methods and findings please go to CMS' Medicare Hospice Center website at <http://www.cms.gov/Center/Provider-Type/Hospice-Center.html>.

A link to the proposed rule, which will be published in the *Federal Register* on May 13, 2013, is available at: <https://www.federalregister.gov/public-inspection>.

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From: Chadwick, Alpheus K. (CMS/OL)
Sent: 16 Aug 2011 09:33:47 -0400
To: Bucklen, Kim L. (CMS/CQISCO);Howell, Cherie A. (CMS/OL);'Aderholt, Robert' (megan.medley@mail.house.gov);'Bachus, Spencer' (philip.swartzfager@mail.house.gov);Bishop, Cameron (Rogers);Mo Brooks (pettitt, mark) (mark.pettitt@mail.house.gov);Newton, Andrew (Shelby) [Andrew_Newton@shelby.senate.gov];'Rep. Bonner (Strange, Luke)';Richard Shelby (graham_smith@shelby.senate.gov);Roby, Martha (frank.barnett@mail.house.gov);Sewell, Terri (Abney, Allison);Walton, Hunter (Sessions);Adams, Sandy (Courtney Arnold);Ahn, Susie (Bill Nelson);Alcee Hastings (Christian.Sy@mail.house.gov);Bassett, Michael (Aging);Bilirakis, Gus;Bill Nelson (gene_schlesinger@billnelson.senate.gov);Brown Waite, Ginny;Brown, Corrine;Brown, Corrine (mike.collins@mail.house.gov);Castor, Kathy;Crenshaw, Ander;Debbie Wasserman Schultz (Danielle Gilbert);John Mica (Casey.Brinck@mail.house.gov);Mack, Connie (sarah.krug@mail.house.gov);Nugent, Richard (Katherine Troller);Posey, Bill;Reid, Jocelyn;Rivera, David (Hector Arguello);Rooney, Tom (jessica.moore@mail.house.gov);'Ros-Lehtinen, Ileana (guillermo.vallejo@mail.house.gov)';Ross, Dennis (Charles Flint);Rubio, Marco (Sally Canfield);PSC Karen.williams mail.house.gov;Stearns, Cliff (thomas.power@mail.house.gov);Vern Buchanan (Shane Lieberman);Wasserman Schultz, Debbie (Dolan, Coby);Webster, Daniel (Elizabeth Smokay);West, Allen (Josh Grodin);Wilson, Frederica (Michael Ashley);Young, Bill C.W.;'Barrow, John (aaron.schmidt@mail.house.gov)';Barrow, John (hill.thomas@mail.house.gov);Bishop, Sanford (jonathan.halpern@mail.house.gov);Chamblis, Saxby (richard_gerakitis@chambliss.senate.gov);Deal, Nathan (josh.finestone@mail.house.gov);Graves, Tom (jason.murphy@mail.house.gov);Isakson, Johnny (Isakson);Johnson, Hank (scott.goldstein@mail.house.gov);Kingston, Jack (Vermeesch, Kristyn);'Lewis, John';'Linder, John (Don.Green@mail.house.gov)';Paul Broun (joe.murray@mail.house.gov);'Price, Tom';'Price, Tom (Emily Henehan)';robert.horne@mail.house.gov;Scott, Austin (Jessica Robertson);'Scott, David (McAthey, Tammy)';Westmoreland, Lynn (Austin, Lindsay);Woodall, Rob (Janet Rossi);Chandler, Ben (robert.kramer@mail.house.gov);'Davis, Geoff (Armstrong Robinson)';John A. Yarmuth (Hagan, Colleen);'McConnell, Mitch';O'Brien, Lauren;Paul, Rand (Bonnie Honaker);Paul, Rand (Seana Cranston);Rogers, Harold (aaron.jones@mail.house.gov);Whitfield, Edward (jeff.mortier@mail.house.gov);Cochran, Thad (elyse_marcellino@cochran.senate.gov);Harper, Gregg (scot.malvaney@mail.house.gov);Nunnelee, Alan (Meyer.Seligman@mail.house.gov);Steven Palazzo (brett.richards@mail.house.gov);'Thompson, Bennie';Thompson, Bennie (TSMITH@mail.house.gov);Wicker, Roger (Wesley Clay);(Esther_Clark@burr.senate.gov);(Judy_Shaffner@burr.senate.gov);(Susan_Hatfield@burr.senate.gov);Abram, Anna (HELP Committee);Adams, Michelle (Hagan);Burr, Richard (Andrea_Davis@burr.senate.gov);'Coble, Howard';Ellmers, Renee (Josh Babb);Hagan, Kay (mike_harney@hagan.senate.gov);Jones, Walter (joshua.bowlen@mail.house.gov);Larry Kissell;Lindsay, Jason (Hagan) [Jason_Lindsay@hagan.senate.gov];'McHenry, Patrick';McIntyre, Mike (Milligan, Blair)';Miller, Brad (heather.parsons@mail.house.gov);Myrick, Sue (sarah.hale@mail.house.gov);Price, David;Shuler, Heath (Erin.Doty@mail.house.gov)';Tonya Williams (G.K. Butterfield) (tonya.n.williams@mail.house.gov);Tracy Zvenyach (Hagan);Virginia Foxx (leslie.goodman@mail.house.gov);Virginia Foxx (Michael James);'Watt, Melvin';Aramanda, Alec (DeMint)';Clyburn, James';Duncan, Jeff (Jordan Sherer);Gowdy, Trey (Beth Webb);Graham, Lindsey (colin_allen@lgraham.senate.gov);Mulvaney, Mick (Matt Carter);Scott, Tim (Tara O'Neal);Wilson, Joe (melissa.chandler@mail.house.gov);Black, Diane (Brian Lenihan);'Blackburn, Marsha (Cara Dalmolin)';Cohen, Steve (brittany.johnson@mail.house.gov);Cooper, Jim (elizabeth.falcone@mail.house.gov);Cooper, Jim (ruth.mcdonald@mail.house.gov);'Corker, Bob';Corker, Bob (John Goetz);OS Vaughn, Richard;Fincher, Stephen (Chris Davis);Fleishmann, Charles (Jordan Spencer);John Duncan (patra.stephan@mail.house.gov);Lamar Alexander

(marysumpter_lapinski@alexander.senate.gov);Phil Roe;Swager, Curtis (Alexander)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Implementation of Section 5503 of the Affordable Care Act

U.S. House and Senate Notification
Monday, August 15, 2011

To: Healthcare Staff

From: Amy Hall, Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Implementation of Section 5503 of the Affordable Care Act

Late last week, the Centers for Medicare & Medicaid Services (CMS) sent letters to affected hospitals notifying them about the distribution of additional residency positions under Section 5503 of the Affordable Care Act. Section 5503 reduced the full-time equivalent (FTE) resident caps for certain teaching hospitals who were not training up to their caps and authorized the redistribution of such positions to other qualified teaching hospitals.

We anticipate that hospitals will receive the letters from CMS regarding the additional positions early this week. In total, approximately 628 indirect medical education (IME) and 726 direct graduate medical education (DGME) slots were redistributed under this provision. To provide some context, under section 422 of the Medicare Modernization Act, about 3,000 IME and 2,600 DGME slots were redistributed.

For further information, please visit http://www.cms.gov/AcuteInpatientPPS/06_dgme.asp#TopOfPage . If you have any questions, please contact the CMS Office of Legislation. Thank you.

Chadwick, Alpheus K. (CMS/OL)


From: Yen, Lisa (CMS/OL)
Sent: Thursday, January 7, 2010 2:44 PM
To: Murry, Emily (Henehan)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Clapton, Erin M. (CMS/OL)
Subject: RE: Competitive Bidding

Hi Emily – Sure, no problem. The other CMS participants on the call were Carol Blackford, Joel Kaiser (in Laurence Wilson's group) and Al Chadwick (in the Office of Legislation).

Let me know if you have further questions.

Thanks,
Lisa

Lisa Yen
Office of Legislation / Centers for Medicare & Medicaid Services
202.690.5524 (phone) 202.690.8168 (fax)

 Please consider the environment before printing this e-mail.

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Thursday, January 07, 2010 1:55 PM
To: Yen, Lisa (CMS/OL)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Clapton, Erin M. (CMS/OL)
Subject: RE: Competitive Bidding

..isa,

Thank you for setting up the call a few weeks ago. Unfortunately, I wasn't able to get everyone's name that was on the call (other than Laurence D. Wilson Director, Chronic Care Policy Group).

Would you mind providing me the names of those other individuals for my records?

Thanks!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman


From: Yen, Lisa (CMS/OL) [mailto:Lisa.Yen@cms.hhs.gov]
Sent: Tuesday, December 22, 2009 11:33 AM
To: Murry, Emily (Henehan)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Clapton, Erin M. (CMS/OL)
Subject: RE: Competitive Bidding

Hi Emily – Just confirming that we are still on for the call today at 1 PM. The call-in number is 1.877.267.1577 and the pin code is

Email or call me if you have any problems calling in.

Thanks,
Lisa

Lisa Yen
Office of Legislation / Centers for Medicare & Medicaid Services
202.690.5524 (phone) 202.690.8168 (fax)

 Please consider the environment before printing this e-mail.

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Thursday, December 17, 2009 5:31 PM
To: Clapton, Erin M. (CMS/OL)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding

That will work perfectly.

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Clapton, Erin M. (CMS/OL) [mailto:erin.clapton@cms.hhs.gov]
Sent: Thursday, December 17, 2009 5:22 PM
To: Murry, Emily (Henehan)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding
Importance: High

Sorry – meant to say 1:00pm on Tuesday, December 22? Our program expert is on call for jury duty on Monday.

Erin M. Clapton
Director
Medicare Part A & Part B Analysis Group
CMS Office of Legislation

From: Clapton, Erin M. (CMS/OL)
Sent: Thursday, December 17, 2009 5:21 PM
To: 'Murry, Emily (Henehan)'
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding

How about 1:00pm on Monday, December 21? If that works, I'll send you a call-in number for the call.

Erin M. Clapton
Director
Medicare Part A & Part B Analysis Group
CMS Office of Legislation

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Wednesday, December 16, 2009 5:48 PM
To: Clapton, Erin M. (CMS/OL)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding

Sorry – Monday anytime after 12:30 or anytime Tuesday except between 11:00 and 11:30am.

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Clapton, Erin M. (CMS/OL) [mailto:erin.clapton@cms.hhs.gov]
Sent: Wednesday, December 16, 2009 4:46 PM
To: Murry, Emily (Henehan)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding

So Monday morning or anytime Tuesday except between 11:00 and 11:30am, right?

Erin M. Clapton
Director
Medicare Part A & Part B Analysis Group
CMS Office of Legislation

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Wednesday, December 16, 2009 4:37 PM
To: Clapton, Erin M. (CMS/OL)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding

Sure – Monday anytime but after 12:30, Tuesday anytime but 11-11:30. I am gone starting Wednesday.

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Clapton, Erin M. (CMS/OL) [mailto:erin.clapton@cms.hhs.gov]
Sent: Wednesday, December 16, 2009 4:34 PM
To: Murry, Emily (Henehan)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding

Do you have any availability the following week? Our program experts are not available tomorrow and are pretty booked already for Friday.

Erin M. Clapton
Director
Medicare Part A & Part B Analysis Group
CMS Office of Legislation

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Wednesday, December 16, 2009 4:32 PM
To: Clapton, Erin M. (CMS/OL)
Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)
Subject: RE: Competitive Bidding

Sure that would be great! I am free anytime tomorrow but 10-11am tomorrow and all day Friday.

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Clapton, Erin M. (CMS/OL) [mailto:erin.clapton@cms.hhs.gov]
Sent: Wednesday, December 16, 2009 4:13 PM
To: Murry, Emily (Henehan)

Cc: Smith, Amelia I. (CMS/OL); Chadwick, Alpheus K. (CMS/OL); Yen, Lisa (CMS/OL)

Subject: RE: Competitive Bidding

Hi Emily. Al forwarded your request to me. I would be happy to schedule this. Would a conference call be acceptable?

Since we are nearing the holidays, I am not sure about the availability of our program experts but if you could identify some dates and times that work for you, I will work to set something up.

Thanks.

Erin M. Clapton
Director
Medicare Part A & Part B Analysis Group
CMS Office of Legislation

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]

Sent: Wednesday, December 16, 2009 2:55 PM

To: Chadwick, Alpheus K. (CMS/OL)

Subject: Competitive Bidding

Al,

I was hoping I could talk with someone at CMS about the new CB process and why some of the changes weren't made/problems still exist. I was also hoping to find out why certain methodologies were used. In particular:

- 1) why was the PAOC recommendations not asked for?
- 2) Why were their previous recommendations not incorporated?
- 3) Did the GAO study do address the significant variation in bid rates for the exact same product billing codes across bidding areas.
- 4) Did CBO come up with how to set the bid rate (median of lowest 3 bids)
- 5) Why are suppliers who are not in the area still allowed to bid for and win bids?
- 6) Why cant CMS make sure those who bud can handle the business (% of market) and also have the financial ability to actually sustain on the price bid? We heard that the tax returns that are submitted aren't even verified – why?

Thanks!

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., *Chairman*
424 Cannon Building
202-225-4501

Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Wednesday, April 14, 2010 3:03 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: CMS office of the Actuary

Shoot I just got your vmail – I will give you a ring now!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Murry, Emily (Henehan)
Sent: Wednesday, April 14, 2010 12:36 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: RE: CMS office of the Actuary

Hey I also wanted to follow up on this – if you are not the right person to ask my bad I can just call the liaison number and find out who to contact!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Murry, Emily (Henehan)
Sent: Thursday, April 08, 2010 4:08 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: CMS office of the Actuary

Al,

I was wondering if you or someone at CMS could provide me with information about the rules surrounding when or even if the CMS Office of the Actuary (OACT) has to provide a report upon Congress' requests. Specifically, I am referring to the request for a report on HR 3590 that CMS OACT said it could not produce in time for the vote and if they are still working on this. My boss was wondering if they had to produce something within a certain timeframe if asked or how it all works.

Thanks!

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., *Chairman*
424 Cannon Building
202-225-4501



Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Thursday, April 15, 2010 12:17 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Another request for information regarding participating physicians

Great thanks!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Thursday, April 15, 2010 12:01 PM
To: Murry, Emily (Henehan)
Subject: RE: Another request for information regarding participating physicians

Emily, thanks for the clarification. As of July 2007, there were 1,087,845 practitioners participating in Medicare (see attached). CMS does not maintain data on the number of practitioners participating in Medicaid as practitioners register with each state and not CMS. I hope this helps.

-AI

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Wednesday, April 14, 2010 12:34 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Another request for information regarding participating physicians

Hey AI - actually this is not what we are looking for (the site is for patients we are trying to get raw data on the number of overall participating Medicare and Medicaid providers. IE I know that they all have to have individual provider numbers so I am assuming that HHS/CMS keeps a list of the total number of such providers but I cannot find that (I don't need the specific names or provider number just the total figure).

Thanks!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Tuesday, April 13, 2010 1:32 PM
To: Murry, Emily (Henehan)
Subject: RE: Another request for information regarding participating physicians

Emily, our www.medicare.gov website has a link to the information you are looking for at <http://www.medicare.gov/Physician/Search/PhysicianSearch.asp>. You may contact me if you have any questions or need me to walk you through the site. Thanks.

-AI

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Monday, April 12, 2010 6:10 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Another request for information regarding participating physicians

Al,

I was hoping you could point me to the right website or perhaps you have a document outlining the number of participating / practicing physicians who accept Medicare and Medicaid. It would be great if there was a national and state by state breakdown!

Thanks.

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., *Chairman*
424 Cannon Building
202-225-4501



Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Friday, April 23, 2010 4:23 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: CMS office of the Actuary

Thanks so much!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Friday, April 23, 2010 4:22 PM
To: Murry, Emily (Henehan)
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: CMS office of the Actuary

Hi Emily,

As a follow-up to your previous inquiry, attached are two memoranda, showing:

- i. The overall financial, coverage, and NHE effects of the Patient Protection and Affordable Care Act, as enacted on March 23, 2010 (P.L. 111-148) and amended by the Health Care and Education Reconciliation Act of 2010 on March 30 (P.L. 111-152); and
- ii. The specific impacts on the HI trust fund exhaustion date, on Part B premiums, and on Part A and Part B average coinsurance amounts.

Thanks very much, and please let me know if you have any questions.

-AI

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Monday, April 19, 2010 3:00 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: CMS office of the Actuary

Thanks AI – that is what I thought but some people here on the hill were under the impression there was a more formal arrangement!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Monday, April 19, 2010 2:29 PM
To: Murry, Emily (Henehan)

Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: CMS office of the Actuary

Emily,

In general, there aren't any written requirements for Congressional requests made to the Office of the Actuary at CMS. There is, of course, a longstanding commitment by OACT to provide technical assistance not only to the Administration but also to Congress and to do so in a timely, objective, and nonpartisan manner. Specifically, the request to provide an analysis of the PPACA reconciliation amendments was received 3 days preceding the day the House vote on March 21. Therefore, the OACT did not have enough time to examine the legislative changes and estimate their financial and other effects prior to the vote.

OACT continues to work on the estimates for PPACA as enacted and amended and anticipates that the analysis will be completed soon. I will ensure you receive a copy. Thanks.

-Al

From: Murry, Emily (Henehan)
Sent: Thursday, April 08, 2010 4:08 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: CMS office of the Actuary

Al,

I was wondering if you or someone at CMS could provide me with information about the rules surrounding when or even if the CMS Office of the Actuary (OACT) has to provide a report upon Congress' requests. Specifically, I am referring to the request for a report on HR 3590 that CMS OACT said it could not produce in time for the vote and if they are still working on this. My boss was wondering if they had to produce something within a certain timeframe if asked or how it all works.

Thanks!

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., *Chairman*
424 Cannon Building
202-225-4501



||||

Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Friday, April 30, 2010 9:30 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: contact information for CMS officials

Al,

I called the office and they confirmed that if I just send the letters to the general address people will get them – so were good thanks!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Murry, Emily (Henehan)
Sent: Thursday, April 29, 2010 3:31 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: contact information for CMS officials

Al,

I looked online but couldn't find the correct address to send a letter from congressman price to the following people (I just want to make sure I have the correct addresses!)

Ms. Marilyn Tavenner
Principal Deputy Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Hubert Humphrey Building
Washington, D.C. 20201

Mr. Jonathan Blum
Deputy Administrator for Medicare
7500 Security Blvd
Baltimore, MD 21244

Ms. Liz Richter
Deputy Director of the Center for Medicare Management
7500 Security Blvd
Baltimore, MD 21244

Ms. Amy Bassano
Director of the Hospital & Ambulatory Policy Group
7500 Security Blvd
Baltimore, MD 21244

Mr. Christine Smith-Ritter
Acting Director of the Division of Outpatient Care

7500 Security Blvd
Baltimore, MD 21244

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., *Chairman*
424 Cannon Building
202-225-4501



Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Friday, May 21, 2010 1:23 PM
To: Howell, Cherie A. (CMS/OL)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: HHS/CMS responsibilities and regs timeline

This is great thanks!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Howell, Cherie A. (CMS/OL) [mailto:Cherie.Howell@cms.hhs.gov]
Sent: Wednesday, May 19, 2010 11:17 AM
To: Murry, Emily (Henehan)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: HHS/CMS responsibilities and regs timeline

<http://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf>
For other HHS provision contact ASL at 202-690-7450

Other health reform information can be found at <http://www.cms.gov/Center/healthreform.asp>

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Wednesday, May 19, 2010 10:19 AM
To: Howell, Cherie A. (CMS/OL)
Subject: HHS/CMS responsibilities and regs timeline

Cherie,

Thanks for any and all info you can provide. We have a lot of people asking when they need to submit comments, what the secretary has put out official regs on or asked for from NAIC, states, etc to date and through the end of the year.

If there is someone else at HHS that I need to reach out to non-CMS info I will do that as well.

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., *Chairman*
424 Cannon Building
202-225-4501



Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Tuesday, June 29, 2010 12:50 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Question about Medicare and Electronic funds transfer system

Thanks Al – they were unclear why they were classified as a new provider and had redo all the paperwork just because they moved and were trying to get a rationale for the rule change. I believe I found it - on May 5th, it is titled "Medicare and Medicaid Programs, Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements, and Changes in Provider Agreements."

<http://edocket.access.gpo.gov/2010/pdf/2010-10505.pdf>

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Thursday, June 24, 2010 11:31 AM
To: Murry, Emily (Henehan)
Subject: RE: Question about Medicare and Electronic funds transfer system

Federal Regulations found at 42 CFR 424.510(d)(2)(iv) speak to the "Requirements for enrolling in the Medicare program"; specifically, EFT. It may be helpful to let me know more specifics regarding the constituents problem. Thx.

-Al

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Tuesday, June 22, 2010 4:07 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Question about Medicare and Electronic funds transfer system

Do you or can you direct me to where I can get information for a constituent on a physician who is dealing with the Medicare electronic funds transfer system.

Apparently, Medicare has chosen to classify folks who have changed the address of their practice to be new practices and thus required to fill out a whole bunch of paperwork.

I am trying to figure out what law or subsequent regulation made the change to classify those switching to electronic transfers as new?

I am continuing to look into this but if you have any information that would be much appreciated!

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., Chairman
424 Cannon Building
202-225-4501



Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Wednesday, June 30, 2010 12:25 PM
To: Howell, Cherie A. (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Hill Notification: The 2010 Medicare Physician Fee Schedule

Cherie and Al,

I contacted the Office of Legislation but they said to contact you.

Congressman Price wanted to inquire about where in the process the testing and actual processing of payments is for the 2.2% increase as we have had a lot of physicians contact us about this. To confirm – you will begin processing new claims at the increased rate starting on the 1st and “Claims containing June 2010 dates of service which have been paid at the negative update rates will be reprocessed as soon as possible.” Any more information on the timeline for re-processed payments or if the new payments have started to go out?

Any update would be helpful!

Emily Henehan Murry

U.S. House Republican Study Committee (RSC)

Congressman Tom Price, M.D., Chairman

From: Howell, Cherie A. (CMS/OL) [mailto:Cherie.Howell@cms.hhs.gov]
Sent: Friday, June 25, 2010 3:12 PM
To: Chadwick, Alpheus K. (CMS/OL); Bucklen, Kim L. (CMS/CQISCO); Medley, Megan; Swartzfager, Philip; Ginty, Bess; Appel, Erika; Huskey, Marcus; Strange, Luke; graham_smith@shelby.senate.gov; Walton, Hunter; caroline_walker@sessions.senate.gov; Anderson, Sandra (LeMieux); Bassett, Michael (Aging); White, Jerry; Cates, Clint; Grabelle, Justin; Martinelli, Nick; Mitchell, Todd; Christian, Courtney; Cho, James; Riska, Nathan; Gilbert, Danielle; Fisher, Christopher; Gonzalez, Cesar; Robitaille, Lauren; Stoller, Matt; Greene, Amye; Brinck, Casey; Gwynn-Sackson, Peter; Subramanyam, Suhas; rosenancy_joseph@LeMieux.senate.gov; taylor_booth@lemieux.senate.gov; Krug, Sarah; Mahood, Lane (Martinez); Williams, Clarence; Speer, Kim; Nelson, Bill (Madeline Otto); Burns, Stuart; ashley.fishburn@mail.house.gov; Moore, Jessica; Vallejo, Guillermo; Power, Thomas; Dolan, Coby; Wexler, Robert ('Dominguez, Eva'); Stine, Brad; Schmidt, Aaron; Halpern, Jonathan; Chambliss, Saxby; Fulenwider, Blake; Horne, Robert; Isakson, Johnny (Isakson); Goldstein, Scott; Gilley, Meg; Crowell, Michaeleen; Green, Don (Buchanan); Nelson, Tim; Murray, Joe; Price, Thomas; Murry, Emily (Henehan); McAthey, Tammy; Austin, Lindsay; Bunning, Jim; Bunning, Jim; Kramer, Robert; Robinson, Armstrong; Weatherby, Jasmine; McConnell, Mitch; O'Brien, Lauren; Jones, Aaron; Mortier, Jeff; Buckalew, Adam; Materio, Jenny; saralove_swaney@cochran.senate.gov; will_crump@cochran.senate.gov; Malvaney, Scot; Horton, Cory; Martin, Brian (Taylor); Avant, Lanier; Smith, Tara; susan_sweat@wicker.senate.gov; Esther_Clark@burr.senate.gov; Judy_Shaffner@burr.senate.gov; Susan_Hatfield@burr.senate.gov; Abram, Anna (HELP Committee); Adams, Michelle (Hagan); Andrea_Davis@burr.senate.gov; Jennifer_Nardi@help.senate.gov; Willis, Ken; Miller, Jane; McCrimmon, LaTanta; Shrader, Erica; mike_harney@hagan.senate.gov; Murray, Jerome; Roehrenbeck, Cybil; Mitchell, Bryan; Meek, Nancy; Milligan, Blair; Parsons, Heather; Hale, Sarah; Thrift, Laura; Georges, Erin (Doty); Skouras, Spyros; Hooper, Laura; Miller, James; Holt, Chris; McGee, Corey; Singletary, Barvetta; monica_henriques@demint.senate.gov; colin_allen@lgraham.senate.gov; matt_hoskins@demint.senate.gov; Palmer, Ashli; Chandler, Melissa; Alexander, Lamar (Lapinski, MarySumpter (HELP Committee)); Dalmolin, Cara; Johnson, Brittany; Falcone, Elizabeth; Corker, Bob; Corker, Bob (John Goetz); Hennigan, Caroline; Lichtenberg, Dana; Stephan, Patra; Meyer, Matt; Swager, Curtis (Alexander); Brown, Elizabeth; Frierson, John
Cc: Martino, Maria (CMS/OL)
Subject: Hill Notification: The 2010 Medicare Physician Fee Schedule

|| U.S. House and Senate Notification

Friday, June 25, 2010

To: Congressional Health Legislative Assistant

**From: Amy Hall
Director, Office of Legislation
Centers for Medicare & Medicaid Services**

Re: The 2010 Medicare Physician Fee Schedule

On June 25, 2010, President Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010." This law establishes a 2.2 percent update to the Medicare Physician Fee Schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010. The Centers for Medicare & Medicaid Services (CMS) has directed Medicare claims administration contractors to discontinue processing claims at the negative update rates and to temporarily hold all claims for services rendered June 1, 2010, and later, until the new 2.2 percent update rates are tested and loaded into the Medicare contractors' claims processing systems. Effective testing of the new 2.2 percent update will ensure that claims are correctly paid at the new rates. We expect to begin processing claims at the new rates no later than July 1, 2010. Claims for services rendered prior to June 1, 2010, will continue to be processed and paid as usual.

Claims containing June 2010 dates of service which have been paid at the negative update rates will be reprocessed as soon as possible. Under current law, Medicare payments to physicians and other providers paid under the MPFS are based upon the lesser of the submitted charge on the claim or the MPFS amount. Claims containing June dates of service that were submitted with charges greater than or equal to the new 2.2 percent update rates will be automatically reprocessed. Affected physicians/providers who submitted claims containing June dates of service with charges less than the 2.2 percent update amount will need to contact their local Medicare contractor to request an adjustment. Submitted charges on claims cannot be altered without a request from the physician/provider. Physicians/providers should not resubmit claims already submitted to their Medicare contractor.

Please contact the CMS Office of Legislation if you have any questions. Thank you.

Chadwick, Alpheus K. (CMS/OL)

From: Murry, Emily (Henehan) <emily.murry@mail.house.gov>
Sent: Wednesday, September 15, 2010 5:47 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Question about Medicare and Electronic funds transfer system

Hey Al - per our call yesterday - were you able to track down if this came from a bill or if it was just a reg done at CMS' discretion?

Thanks!

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Murry, Emily (Henehan)
Sent: Monday, September 13, 2010 9:03 AM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: RE: Question about Medicare and Electronic funds transfer system

Hey wanted to check on this and see if you were able to find any more information on the below inquiry? Should I give you a call to further explain?

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Murry, Emily (Henehan)
Sent: Wednesday, August 04, 2010 3:43 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: RE: Question about Medicare and Electronic funds transfer system

Sorry for the delay – thanks for the info – my question is what bill specifically required this to occur (what were the regs promulgated in response to? MIPPA?).

Our constituent's concern is that they have entirely re-fill out the paperwork just because they moved offices.

Thanks1

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Thursday, June 24, 2010 11:31 AM
To: Murry, Emily (Henehan)
Subject: RE: Question about Medicare and Electronic funds transfer system

Federal Regulations found at 42 CFR 424.510(d)(2)(iv) speak to the "Requirements for enrolling in the Medicare program"; specifically, EFT. It may be helpful to let me know more specifics regarding the constituents problem. Thx.

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Tuesday, June 22, 2010 4:07 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Question about Medicare and Electronic funds transfer system

Do you or can you direct me to where I can get information for a constituent on a physician who is dealing with the Medicare electronic funds transfer system.

Apparently, Medicare has chosen to classify folks who have changed the address of their practice to be new practices and thus required to fill out a whole bunch of paperwork.

I am trying to figure out what law or subsequent regulation made the change to classify those switching to electronic transfers as new?

I am continuing to look into this but if you have any information that would be much appreciated!

Emily Henehan Murry
Professional Staff Member
Republican Study Committee (RSC)
Office of Rep. Tom Price, M.D., *Chairman*
424 Cannon Building
202-225-4501



Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Tuesday, December 7, 2010 4:40 PM
To: Murry, Emily (Henehan)
Cc: Martino, Maria (CMS/OL)
Subject: RE: Hill Notification: CMS Issues CY 2011 Policy and Payment Rate Changes for the Medicare Physician Fee Schedule

Emily, there are no rulemaking issues as a result of H.R. 5712, so we will revise the CY 2011 PFS and then issue instructions to our contractors. Will keep you posted. I hope this helps.

-Al

From: Murry, Emily (Henehan) [mailto:emily.murry@mail.house.gov]
Sent: Tuesday, December 07, 2010 11:27 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Hill Notification: CMS Issues CY 2011 Policy and Payment Rate Changes for the Medicare Physician Fee Schedule

Al – do you know if CMS is going to have to redo this reg now that the savings generated from the reduction to multiple therapy services is being used to pay for the doc fix instead of going back into the PFS?

The bill was passed last week (HR 5712)

Emily Henehan Murry
U.S. House Republican Study Committee (RSC)
Congressman Tom Price, M.D., Chairman

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Wednesday, November 03, 2010 10:13 AM
To: Bucklen, Kim L. (CMS/CQISCO); Howell, Cherie A. (CMS/OL); Medley, Megan; Swartzfager, Philip; Lofton, Lane; Appel, Erika; Newton, Andrew (Sessions); Huskey, Marcus; Strange, Luke; Richard Shelby (graham_smith@shelby.senate.gov); Walton, Hunter; Cooper, Charles; Ahn, Susie (Bill Nelson); Sy, Christian; Anderson, Sandra (LeMieux); Bassett, Michael (Aging); White, Jerry; Bill Nelson (gene_schlesinger@billnelson.senate.gov); Cates, Clint; Grabelle, Justin; Martinelli, Nick; Mitchell, Todd; Christian, Courtney; Cho, James; Riska, Nathan; Gilbert, Danielle; Fisher, Christopher; Mendoza, Miguel; Stoller, Matt; Hammond, Yonnick; Brinck, Casey; Gwynn-Sackson, Peter; Subramanyam, Suhas; LeMieux, George (Rosenancy_Joseph@LeMieux.senate.gov); LeMieux, George (taylor_booth@lemieux.senate.gov); Morley, Autumn; Krug, Sarah; Williams, Clarence; Burns, Stuart; Reid, Jocelyn; Moore, Jessica; Vallejo, Guillermo; Power, Thomas; Vasilaros, Nicole; Dolan, Coby; Stine, Brad; Schmidt, Aaron; Thomas, Hill; Halpern, Jonathan; 'Chambliss, Saxby'; Deal, Nathan (blake.fulenwider@mail.house.gov); Horne, Robert; Isakson, Johnny (Isakson); Thigpen, Allison; Goldstein, Scott; Crowell, Michaeleen; Green, Don (Buchanan); Nelson, Tim; Murray, Joe; Price, Thomas; Murry, Emily (Henehan); McAthey, Tammy; Austin, Lindsay; 'Bunning, Jim'; 'Bunning, Jim'; Kramer, Robert; Robinson, Armstrong; Weatherby, Jasmine; 'McConnell, Mitch'; O'Brien, Lauren; Jones, Aaron; Mortier, Jeff; Buckalew, Adam; Materio, Jenny; Cochran, Thad (saralove_swaney@cochran.senate.gov); Cochran, Thad (will_crump@cochran.senate.gov); Malvaney, Scot; Horton, Cory; Martin, Brian (Taylor); Avant, Lanier; Smith, Tara; Wicker, Roger (susan_sweat@wicker.senate.gov); Wicker, Roger (Wesley Clay); (Esther_Clark@burr.senate.gov); (Judy_Shaffner@burr.senate.gov); (Susan_Hatfield@burr.senate.gov); Abram, Anna (HELP Committee); Adams, Michelle (Hagan); Burr, Richard (Andrea_Davis@burr.senate.gov); Burr, Richard (Jennifer_Nardi@help.senate.gov); Willis, Ken; Miller, Jane; McCrimmon, LaTanta; Shrader, Erica; Hagan, Kay (mike_harney@hagan.senate.gov); Murray, Jerome; Jones, Walter (cybil.roehrenbeck@mail.house.gov); Mitchell, Bryan; Meek, Nancy; Milligan, Blair; Parsons, Heather; Hale, Sarah; Thrift, Laura; Georges, Erin (Doty); Skouras, Spyros; Hooper, Laura; Miller, James; Holt, Chris; McGee, Corey; Singletary, Barvetta; DeMint, Jim (monica_henriques@demint.senate.gov); Graham, Lindsey

(colin_allen@lgraham.senate.gov); Jim DeMint (matt_hoskins@demint.senate.gov); Palmer, Ashli; Chandler, Melissa; Alexander, Lamar (Lapinski, MarySumpter (HELP Committee)); Dalmolin, Cara; Johnson, Brittany; Falcone, Elizabeth; 'Corker, Bob'; Corker, Bob (John Goetz); Davis, Lincoln (caroline.hennigan@mail.house.gov); Lichtenberg, Dana; Stephan, Patra; Meyer, Matt; Thompson, Doug; Swager, Curtis (Alexander); Frierson, John
Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS Issues CY 2011 Policy and Payment Rate Changes for the Medicare Physician Fee Schedule

U.S. House and Senate Notification

November 3, 2010

To: Congressional Health Staff

From: Amy Hall

Director, Office of Legislation

Centers for Medicare & Medicaid Services

Re: CMS Issues CY 2011 Policy and Payment Rate Changes for the Medicare Physician Fee Schedule

Yesterday, the Centers for Medicare & Medicaid Services (CMS) released a final rule making payment and policy changes for services furnished under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2011. The final rule also implements a number of provisions of the Affordable Care Act that expand preventive services for Medicare beneficiaries, improve payments for primary care services, and promote access to health care services in rural areas. The new policies will apply to payments under the Medicare Physician Fee Schedule (MPFS) for services furnished on or after January 1, 2011.

More specifically, the final rule implements provisions in the Affordable Care Act that enhance beneficiary access to preventive services and, for the first time, provide coverage under the traditional fee-for-service program for an annual wellness visit beginning January 1, 2011. The rule also eliminates out-of-pocket costs for most preventive services beginning January 1, 2011. In addition, the final rule implements provisions that would enhance beneficiaries' access to care, including a policy providing a 10 percent incentive payment for primary care services furnished by primary care practitioners, and a 10 percent incentive payment to general surgeons performing major surgery in designated provider shortage areas.

Please find attached a press release and fact sheets about this final rule. If you have any questions about this announcement, please contact the CMS Office of Legislation at 202-690-8220. Thank you.

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Wednesday, February 8, 2012 3:40 PM
To: Natalie.Burkhalter@mail.house.gov
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: GME cap

Natalie – to follow-up on our conversation, please see our web site, which includes general information about the resident redistribution, specific references to the rules regarding resident redistribution, and lists of hospitals that received slots: http://www.cms.gov/AcuteInpatientPPS/06_dgme.asp . In general, the slots that were redistributed were slots that were reflected on the cost report. After you take a look at the information on our website, let me know if you would like to discuss. Thx.

-AI

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Wednesday, February 08, 2012 12:00 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: GME cap

Hi AI,

Our constituent is trying to find out if it is accurate that CMS is considering residents that did electives in "de novo" hospitals as counting towards the cap, regardless of whether a cost report was generated and whether IRIS is used to cross reference.

I believe they are referring to a March rule that complies with PPACA's reductions in resident caps for some hospitals. I just wanted to get a little more clarification on how resident cap reductions are determined and what hospitals are affected.

Thanks so much for your help.

Natalie Burkhalter
Office of Congressman Tom Price, M.D. (GA-06)
403 Cannon House Office Building
Washington, D.C. 20515
p: (202) 225-4501
f: (202) 225-4656

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Thursday, June 21, 2012 10:48 AM
To: 'Natalie.Burkhalter@mail.house.gov'
Subject: Re: mild Procedure Coding

Natalie - I will make sure it gets to the appropriate folks.

-A

Sent from my Blackberry Wireless Device

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Thursday, June 21, 2012 10:38 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: mild Procedure Coding

Hi Al,

I have attached a letter addressed to Administrator Tavenner from Reps. Price and Cassidy on a coverage issue for a procedure for beneficiaries who suffer from conditions, called minimally invasive lumbar decompression procedure or mild. I will of course be mailing a hard copy this morning, but I wanted to be sure the letter got to the appropriate contact at CMS as soon as possible.

Thanks for your help!

Natalie Burkhalter
Policy Advisor Health Care
Office of Congressman Tom Price, M.D. (GA-06)
403 Cannon House Office Building
(202) 225-4501

BILL CASSIDY, M.D.

6TH DISTRICT, LOUISIANA

COMMITTEE ON
ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

SUBCOMMITTEE ON
ENVIRONMENT AND ECONOMY

SUBCOMMITTEE ON
COMMERCE, MANUFACTURING AND TRADE



Congress of the United States
House of Representatives
Washington, DC 20515

WASHINGTON OFFICE:

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WASHINGTON, DC 20515
PHONE: (202) 225-3901
FAX: (202) 225-7313

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BATON ROUGE, LA 70808
PHONE: (225) 979-7711
FAX: (225) 879-7600

<http://cassidy.house.gov>
<http://facebook.com/RepBillCassidy>

June 20, 2012

Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
200 Independence Ave., SW
Room 314G
Washington, DC 20201

Dear Administrator Tavenner:

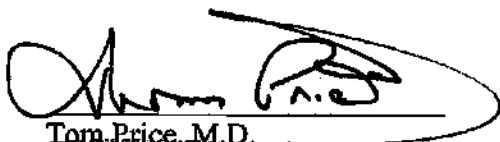
We are writing to you concerning a Medicare coverage and access issue that has recently come to my attention regarding the availability of a minimally invasive, cost effective treatment option for Medicare beneficiaries who suffer from spinal conditions such as lumbar spinal stenosis (LSS).

We understand that Vertos Medical, a device company, has developed a safe and efficacious technique to treat Medicare beneficiaries and other patients with LSS by using the *minimally invasive lumbar decompression* procedure or *mild*®. We have spoken with providers unaffiliated with Vertos who treat LSS and they have confirmed that this is a significant therapy that we need to advance. However, due to a number of technical coding and payment policy hurdles, many beneficiaries do not have access to the technology and may be forced to undergo a more invasive and expensive treatment option, which requires hospitalization.

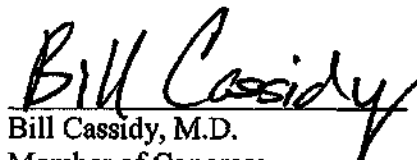
In order to resolve the coding and local coverage issues with this technology, Vertos Medical, at the suggestion of CMS, pursued the American Medical Association's (AMA) Current Procedural Terminology (CPT) coding process. However, the professional group representatives responsible for the spinal care specialty within the AMA's CPT Editorial Panel have made no change to the CPT coding for this technology. Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislatively mandates the use of the AMA's CPT codes for coding and billing, it also requires the use of the CMS' Healthcare Common Procedure Coding System (HCPCS). CMS has the authority to develop procedure codes within the HCPCS manual to serve the needs of the Medicare program and its beneficiaries when the AMA CPT coding process is inadequate.

Ensuring that Medicare participating providers and beneficiaries have access to choose amongst all available technologies allows for physicians and patients to determine the best appropriate treatment plan for them. We are concerned about the lack of access that beneficiaries would have to all available and appropriate treatment options for LSS, including those that are most cost effective for the Medicare program at a time when the solvency of the program is of such significant concern to all Americans. We request that CMS exercise its authority to utilize the HCPCS coding process in this case, or explain the reason for inaction in this area. Thank you for your attention to this matter.

Sincerely,



Tom Price, M.D.
Member of Congress



Bill Cassidy, M.D.
Member of Congress

Cc: Jonathan Blum

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Tuesday, August 14, 2012 8:00 AM
To: Burkhalter, Natalie
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: constituent coding issue

Yes, that still works. This conference call is scheduled to begin on Aug 14, 2012, 10:00 AM EST. To access this conference, please dial 877-267-1577 and when prompted Meeting ID: Please contact me if you have any questions. Thx.

-Al

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Monday, August 13, 2012 5:02 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: constituent coding issue

Hi Al,

Sorry to be slow getting back to you. I could do tomorrow at 10. Let me know if that still works.

Thanks,

Natalie

From: "Chadwick, Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov>
Date: Mon, 13 Aug 2012 09:46:06 -0400
To: Natalie Burkhalter <natalie.burkhalter@mail.house.gov>
Subject: RE: constituent coding issue

Natalie -- are you available on Tuesday, 8/14 at 10am?

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Friday, August 10, 2012 1:29 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: constituent coding issue

Hi Al - I just wanted to check back in with you about the possibility of doing a call sometime next week? Let me know if/when the relevant folks would be available. Thanks.

From: Natalie Burkhalter <natalie.burkhalter@mail.house.gov>
Date: Wed, 1 Aug 2012 18:09:08 -0400
To: "Chadwick, Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov>
Subject: Re: constituent coding issue

Thanks for helping to arrange this call. I can do something next Monday or Tuesday around 10 or 11 am. Let me know if this works, otherwise I can be flexible with times throughout the week.

Thanks!

(202) 225-4501



Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Friday, November 2, 2012 11:20 AM
To: Burkhalter, Natalie
Subject: RE: Home Health Proposal

You can call Mindy Cohen at 202-205-3484 directly regarding your draft.

-Al

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Friday, November 02, 2012 11:12 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: Home Health Proposal

No problem, I will be in touch on those. Who can I expect to hear from about our draft?

On 11/2/12 11:00 AM, "Chadwick, Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov> wrote:

Hello Natalie,

Are the two requests associated with your draft proposal? If not, please send them to me separately.

-Al

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Friday, November 02, 2012 10:46 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: Home Health Proposal

Hi Al,

I just want to follow up on this issue as I am looking to move forward with this draft proposal.

I also have a couple of other questions for you – one regarding a constituent issue with in-office visit requirements for dialysis and the other on EHR meaningful use compliance. If you would prefer that I make those requests separately, please let me know.

Regards,

Natalie Burkhalter
Health Policy Advisor
Republican Policy Committee
Chairman Tom Price, M.D. (GA-06)
Office: (202) 225-4501

On 10/25/12 1:47 PM, "Chadwick, Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov> wrote:
Natalie - I will ask our A/B Analyst Group to call you.

Sent from my Blackberry Wireless Device

From: Burkhalter, Natalie [<mailto:Natalie.Burkhalter@mail.house.gov>]
Sent: Thursday, October 25, 2012 01:15 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: Home Health Proposal

I just want to follow up on this – I am hoping to speak with someone by the end of the week so we can work with CBO and others on the hill.

Thanks!

Natalie

On 10/23/12 12:48 PM, "Burkhalter, Natalie" <natalie.burkhalter@mail.house.gov> wrote:
Hi Al,

I have attached a summary of the larger proposal we are working on and the language for the specific provisions we think would require input from CMS regarding implementation. I was referred to Lauren Aronson by another office I am working with. Please let me know if you or anyone at the office have questions.

Thanks for your consideration,

Natalie Burkhalter
Health Policy Advisor
Republican Policy Committee
Chairman Tom Price, M.D. (GA-06)
Office: (202) 225-4501

SKILLED HOME HEALTHCARE INTEGRITY AND PROGRAM SAVINGS (SHHIPS) PROPOSAL

Section	Provision	Savings	
PROGRAM INTEGRITY	Sec. 101. Preventing entry of individuals with criminal backgrounds.	Requires criminal background checks for all employees with direct patient contact or access to patient records and for all owners and operators as a condition of participation. Contractors are also required to obtain background checks for such personnel. Checks that identify past criminal behavior are required to be reported to HHS and the state in which the agency operates.	
	Sec. 102. Verifying competency through screening and standards.	Requires reasonable and appropriate standards for background screening of owners and managing employees to validate competency according to minimum standards set by the Secretary. The minimum standards criteria for the evaluation of an owner or manager's knowledge of Medicare participation requirements, benefit coverage standards, and reimbursement policies.	
	Sec. 103. Ensuring operational capability to serve beneficiaries.	Adds the following requirements: <ul style="list-style-type: none"> Agencies with new provider number are required to demonstrate proof of sufficient capital to operate for one year. Skilled home health agencies issued a provider number in 2013 or later years are required to provide a \$100,000 surety bond. 	
	Sec. 104. Enforcing provider integrity through compliance/ethics reqts	Directs the Secretary, working jointly with the Inspector General of HHS, to promulgate rules that require skilled home health agencies to have in operation a compliance and ethics program, designed to prevent and detect criminal, civil, and administrative violations.	
	Sec. 105. Temporary entry limitations to prevent excess growth.	Directs the Secretary to suspend the issuance of new home health provider numbers in counties with an over-penetration of providers (defined as counties exceeding the 80th percentile of the number of agencies per 10,000 beneficiaries, which has been correlated with fraud and abuse) for a period of two years or until such time as final regulations are issued to implement the provisions of Title I, to allow time for the implementation of the Act's program integrity protections. Provides for exceptions.	\$3.1 billion
	Sec. 106. Skilled home health provider screening innovator challenge.	Directs the Secretary to establish a "Skilled Home Health Provider Screening Challenge" in which qualified entities will compete to develop software tools to screen Medicare provider applicants. Successful screening software must be capable of risk scoring, credentialing validation, identity authentication, sanction checks, and must reduce administrative and infrastructure expenses.	
	Sec. 107. Effective Dates.	Establishes an effective date of one year after the enactment of the legislation for all program integrity provisions except the temporary entry limitations to prevent excess growth and the skilled home health provider screening innovator challenge, which take effect upon enactment and within 180 days of enactment, respectively. This section also requires the Secretary to issue a report to Congress if implementing regulations have not been promulgated within one year from the date of enactment and stipulates that the temporary limitations to prevent excess growth will remain in effect until these regulations are promulgated.	
	Sec. 201. Preventing the payment of aberrant episode claims.	Establishes reasonable annual payment levels relating to episode utilization rates, with reimbursement limited to the applicable specified rates. Payment limited to no more than 2.7 episodes per beneficiary in non-rural areas and 3.3 episodes per beneficiary in rural areas in each calendar year.	\$13.8 billion
	Sec. 202. Preventing the payment of aberrant LUPA claims.	Establishes reasonable annual payment levels relating to LUPAs, with reimbursement limited to the applicable specified rates. Payment based on a minimum annual LUPA rate of 5% in each calendar year.	\$1.4 billion
	Sec. 203. Ensuring the accuracy of all paid claims.	Directs the Secretary to implement a claims validation process either by a universal or sampling method, so that before payments are made, the Secretary will validate claims on the basis of the submission by a provider of the outcomes and assessment information set (OASIS) or other approved data set. Claims from new agencies (including agencies that experience a change of ownership with a new provider number) would be subject to pre-payment claims review during their first year of operation.	
PAYMENT INTEGRITY			

SECTION	PROVISION	SAVINGS
Sec. 204. Removal of therapy thresholds from payment system.	Directs the Secretary to implement case mix adjustment factors that do not include the level and amount of therapy visits in determining payment amounts.	
Sec. 301. Hospital admission reduction initiative.	Directs the Secretary to establish a skilled home health care hospital admissions and readmissions reductions program. If hospital admissions and readmissions are reduced and savings achieved as a result of the program, then 50 percent of the savings will be redistributed to providers whose own re-admission rates are lower than the national median. The distribution of shared savings payments would be made so that the greatest amount of shared savings are distributed to agencies with the lowest hospital admission and readmission rates.	
Sec. 302. Skilled home health care value based purchasing program.	Directs the Secretary to establish a skilled home health care value-based purchasing program under which value-based incentive payments are made to skilled home health agencies that achieve specified performance scores within a given period of time. The value-based purchasing program would apply to payments made for services provided starting in 2015. The program would be financed by savings achieved through a 1.5% reduction in the standard prospective payment amount for all skilled home health agencies for each episode in a year, which are then redistributed to agencies under the value based purchasing program. The Secretary is directed to develop a methodology for assessing the total performance of each skilled home health agency based on selected measures. Value-based payments for qualifying skilled home health agencies would be applied as a defined percentage add-on payment based on its performance score. This section also permits the Secretary to establish an exceptions process for certain skilled home health providers.	
Sec. 303. Patient assessment and medical direction.	Permits telephonic and two-way audio video communications for the purposes of face-to-face encounters and modifies the physician documentation requirement to require documentation of the date of the encounter. Exempts from the face-to-face encounter requirement all skilled home health patients who are discharged from a hospital or nursing facility within 14 days prior to the initiation of skilled home health services, individuals residing in medically underserved areas, and other individuals as determined by the Secretary where a face-to-face encounter is impracticable, infeasible, or unreasonable.	
Sec. 304. Improved care planning for Medicare skilled home health services.	Allows non-physician providers (defined as nurse practitioners, clinical nurse specialists, certified nurse-midwives physician assistants) to complete the initial patient coverage certification or recertification for additional episodes, under a physician's direct supervision. When a non-physician practitioner provides the certification (or recertification), Medicare would pay a reduced rate for the certification in comparison to the physician payment (85% of the physician payment rate).	\$0.3 billion
Sec. 305. Skilled home health care services.	Adjusts the statutory definitions of Medicare-covered home health care services and home health agencies, and re-designates them as skilled home health care services and skilled home health agencies.	
Total Estimated Savings:		\$18.6 billion

QUALITY

SEC. 201. PREVENTING THE PAYMENT OF ABERRANT EPISODE CLAIMS.

ESTABLISHMENT OF MAXIMUM THRESHOLD FOR EPISODE REIMBURSEMENT.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended by adding after paragraph (6) the following new paragraph—

“(7) EPISODE UTILIZATION RATE.—

“(A) PAYMENT LIMITATION.—For 2013 and each subsequent year, payments may not be made to a skilled home health agency under this section for an episode of care to the extent that it exceeds the applicable episode utilization limit for the agency for the year.

“(B) APPLICABLE EPISODE UTILIZATION LIMIT.—

“(i) IN GENERAL.—For 2013 and each subsequent year, the Secretary shall establish an episode utilization limit for a skilled home health agency that is equal to the product of—

“(I) in the case of a home health agency located in—

“(aa) a rural area, 3.3 episodes; and

“(bb) in an area not described in item (aa), 2.7 episodes;

and

“(II) the total number of Medicare beneficiaries for the skilled home health agency (as determined under clause (iii)).

“(ii) EPISODES.—For purposes of this paragraph, the term ‘episodes’ has the meaning given such term under section 484.205 of title 42, Code of Federal Regulations (as in effect on October 1, 2011) and shall include partial episodes for which a partial episode payment

is made to the extent such partial episode is a percentage of a full episode .

“(iii) TOTAL NUMBER OF MEDICARE BENEFICIARIES.—

“(I) IN GENERAL.—For purposes of this subparagraph, the term ‘total number of Medicare beneficiaries’ means, with respect to a skilled home health agency, the total of the unduplicated number of beneficiaries that were furnished home health services under this title in the year by the home health agency.

“(II) SPECIAL RULE.—In calculating the total number of Medicare beneficiaries that are applicable for an agency’s episode limit under subclause (I), in any case where an individual is furnished skilled home health care services from more than one agency, the number of such beneficiaries being counted toward such agency’s episode limit shall be proportionally credited to each agency in an amount equal to the percentage of the total number of episodes provided by each agency.”.

SEC. 202. PREVENTING THE PAYMENT OF ABERRANT LUPA CLAIMS.

ESTABLISHMENT OF MINIMUM THRESHOLD FOR LOW UTILIZATION PAYMENT ADJUSTMENTS.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) (as amended by section 201) is further amended by adding after paragraph (7) the following new paragraph:

“(8) LOW UTILIZATION PAYMENT ADJUSTMENTS (LUPAS).—

“(A) IN GENERAL.—For 2013 and each subsequent year, the Secretary shall establish a minimum threshold for the Low Utilization Payment

Adjustments (as defined under section 484.205 of title 42, Code of Federal Regulations, as in effect on October 1, 2011) that is equal to 5 percent of total episodes for a home health agency in a year.

“(B) REQUIREMENTS.—The Secretary shall limit payment to the skilled home health agency in accordance with the minimum threshold for the Low Utilization Payment Adjustments under subparagraph (A) and according to the following requirements:

“(i) The Secretary shall limit the aggregate payment to a skilled home health agency so that, as of each payment date, the percentage of non-Low Utilization Payment Adjustment episodes paid to such agency does not exceed 95 percent of total episodes paid to such agency on a cumulative year-to-date basis.

“(ii) On each payment date, to the extent that the percentage of episodes for a skilled home health agency exceeds the percentage under clause (i), the Secretary shall withhold from the payment that would otherwise be applicable an amount equal to—

“(I) such agency’s cumulative average payment rate per episode in the year; minus

“(II) 20 percent of the national standard prospective payment amount under paragraph (3)(A) for the year.

“(C) SPECIAL RULE.—The Secretary shall only include in the calculation of Low Utilization Payment Adjustment episodes for a home health agency in a year under this paragraph such episodes that the Secretary determines were unavoidable according to criteria established by

the Secretary including the death of the beneficiary or the relocation of the beneficiary out of the geographic area of the home health agency.

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Friday, November 2, 2012 11:33 AM
To: Burkhalter, Natalie
Subject: RE: Home Dialysis Physician Visit Requirements

Hello Natalie,

In Change Request 7003 you attached, it states on page 3 in the Policy section that..."Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month."

In short, a decision will be made on a case-by-case basis by our contractor. I hope this helps.

-Al

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Friday, November 02, 2012 11:17 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Home Dialysis Physician Visit Requirements

Hi Al,

I have a constituent who is a long-time dialysis patient and has concerns about the physician visit requirements for in-home dialysis treatment. The rule indicates that these patients must visit their doctor every month, which he and his physician have determined is not necessary. I am hoping to find out if there are exceptions to this requirement or if Medicare does in fact require physicians to see home dialysis patients every month in order to receive reimbursement.

Thanks for you help,

Natalie Burkhalter
Health Policy Advisor
Republican Policy Committee
Chairman Tom Price, M.D. (GA-06)
Office: (202) 225-4501

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Friday, November 30, 2012 1:57 PM
To: Burkhalter, Natalie
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: EHR meaningful use compliance

Hi Natalie,

Yes, it is permissible. Outside of one objective (CPOE), we don't specify how data gets into an EHR to meet these measures. In fact, in the Stage 2 final rule, we were explicit that exchange of information is one of the primary methods through which specialists who do not regularly conduct face-to-face encounters with patients can import data into their EHRs in order to meet these meaningful use measures. Not only does this capture efficiencies within the healthcare system, it also encourages more frequent and robust health information exchange between providers, which is one of the central goals of the EHR Incentive Programs.

Please let me know if you have any questions. Thx.

-Al

From: Burkhalter, Natalie [mailto:Natalie.Burkhalter@mail.house.gov]
Sent: Tuesday, November 27, 2012 2:40 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: HER meaningful use compliance

Hi Al,

I have been hearing from some pathologists in our state that they believe that while it is difficult for pathologists to meet meaningful use requirements, some are doing so by potentially "riding" the data from their academic health center. I think what these providers want to know is whether that is something they can be doing within the rules of meaningful use.

If you could help point me in the right direction I would really appreciate it.

Thanks,

Natalie Burkhalter
Health Policy Advisor
Republican Policy Committee
Chairman Tom Price, M.D. (GA-06)
Office: (202) 225-4501

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Monday, April 15, 2013 9:52 AM
To: 'Natalie.Burkhalter@mail.house.gov'
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Exchanges

Hello Natalie,

Information regarding the Exchange is being developed; however, your constituent can get signed up in REGTAP by going to www.regtap.info and setting up a login—that will let them see upcoming trainings and get on the distribution list for various conference call sessions.

If they are not already, they should also get set up in HIOS, which they can do through the HIOS help desk: HIOS Help Desk at 1-877-343-6507 or insuranceoversight@hhs.gov. I hope this helps.

-Al

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Tuesday, April 09, 2013 5:03 PM
To: 'Natalie.Burkhalter@mail.house.gov'
Cc: Howell, Cherie A. (CMS/OL)
Subject: Re: Exchanges

I will check with staff here and follow-up with you.

-Al

Sent from my Blackberry Wireless Device

From: Burkhalter, Natalie [<mailto:Natalie.Burkhalter@mail.house.gov>]
Sent: Tuesday, April 09, 2013 04:49 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Exchanges

Hi Al,

I have a constituent businessman in the district who is interested in getting some more information on the exchanges and their implementation. I was wondering if there is anyone at CMS who I can put him in contact with?

I appreciate your help!

Natalie Burkhalter

Health Policy Advisor
Rep. Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Phone: (202) 225-4501

Chadwick, Alpheus K. (CMS/OL)

From: Burkhalter, Natalie <Natalie.Burkhalter@mail.house.gov>
Sent: Thursday, May 2, 2013 2:00 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Howell, Cherie A. (CMS/OL)
Subject: Re: Rep. Price (GA) & QIO

Hi Al,

Thanks for keeping me updated. I will be sure to let you know if we have questions.

Thanks,

Natalie Burkhalter
Health Policy Advisor
Rep. Tom Price, M.D. (GA-06)
100 Cannon House Office Building
p: (202) 225-4501

From: <Chadwick>, "Chadwick, Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov>
Date: Thursday, May 2, 2013 12:34 PM
To: Rep Tom Price <natalie.burkhalter@mail.house.gov>
Cc: "Howell, Cherie A. (CMS/OL)" <Cherie.Howell@cms.hhs.gov>
Subject: Rep. Price (GA) & QIO

Hi Natalie,

We wanted to let you know that CMS today issued a request for information (RFI) notice seeking comment about how we can best organize Medicare Quality Improvement Organization (QIO) contractors. This notice was posted to the FedBizOpps.gov website, and comments are requested in the next 30 days.

Beginning in August 2014, CMS will launch the next round of contracts for QIOs, which will be in the 11th Statement of Work. The field of health care quality improvement has changed tremendously since the beginning of the QIO program, and the role of QIOs has evolved from utilization review alone to becoming active facilitators of health care quality improvement with a wide breadth of expertise required. In the RFI, we are seeking comments about four potential options for dividing work among those QIO contractors that will be focused on quality improvement-related work only, as well as alternative approaches that the public could offer for organizing QIO contractors to best achieve the goals of the program. The comments will be used to inform future QIO-related acquisitions.

The document posted today is numbered "HHS-CMS-CCSQ-RFI-13-QIOProgram: Request for Information to Establish Service Areas for Quality Improvement Organizations (QIOs)." It can be found at this website: <http://go.usa.gov/Ty8d>

If you have any questions or we can be of further assistance, please let me know.

-Al

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Thursday, June 20, 2013 9:24 AM
To: Street, Amanda
Subject: RE: Rep. Price (GA) Inquiry re DME CB

Hello Amanda,

I look forward to working with you and if you have any questions, please don't hesitate to ask me. On your physician fee schedule (PFS) question, the proposed rule is usually published around the beginning of July for the coming year and the final rule is published around the beginning of November for the coming year. I will surely notify you once the PFS proposed rule is announced now that I have included you on my GA staff listserv. I hope this helps and let me know if you have any questions.

-Al

From: Street, Amanda [mailto:Amanda.Street@mail.house.gov]
Sent: Thursday, June 20, 2013 9:11 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: Rep. Price (GA) Inquiry re DME CB

Hi Al,

Thank you so much for reaching out to me earlier this week. I greatly appreciate it! As you can imagine, there was little time to get all of the details from Natalie before she left, and I am so thankful for the graciousness everyone has shown me while I'm still fully transitioning into the role.

I have a question for you. Are you able to tell me when CMS will publish the Physician Fee Schedule report? The Congressman would like specific information on the anticipated rates for hip/knee arthroplasties. Is there any way that I could receive that information for him?

Best wishes,

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

From: <Chadwick>, "Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov>
Date: Monday, June 17, 2013 12:32 PM
To: Rep Tom Price <Amanda.Street@mail.house.gov>
Subject: FW: Rep. Price (GA) Inquiry re DME CB

Hello Amanda,

As a follow-up to our conversation, I wanted to check-in on the issue of DME competitive bidding given Rep. Price's interest. We recently provided Rep. Price with our response to

his letter regarding DME competitive bidding (see attached) as well as quality monitoring data at the link below.

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Monitoring.html. To see slides similar to what was shown at the member meeting, click on "Graphs and Summaries for all Product Category Health Outcomes".

If there is any other information or questions regarding DME CB that I can address, please reach out to me. Lastly, it was good to connect with you and I look forward to working with you on Medicare, Medicaid and CHIP issues.

-Al

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Wednesday, May 22, 2013 4:45 PM
To: 'Natalie.Burkhalter@mail.house.gov'
Subject: Rep. Price (GA) Inquiry re DME CB

Hello Natalie,

Please find attached the CMS response to Rep. Price's letter dated March 15, 2013 regarding DME competitive bidding. You may contact me if you have any questions. Thx.

Al Chadwick
Office of Legislation/Congressional Affairs Group
Centers for Medicare & Medicaid Services
200 Independence Ave, SW
Room 351G
Washington, DC 20201
202-690-5519 (Phone)
202-690-8168 (Fax)
alpheus.chadwick@cms.hhs.gov

Chadwick, Alpheus K. (CMS/OL)

From: Street, Amanda <Amanda.Street@mail.house.gov>
Sent: Friday, June 28, 2013 7:52 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: CMS DME Competitive Bidding Response

Hi Al,

Thank you for sending the letter along.

Best,

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

On 6/27/13 6:48 PM, "Chadwick, Alpheus K. (CMS/OL)"
<Alpheus.Chadwick@cms.hhs.gov> wrote:

>Hi Amanda, attached is the response to your bosses June 12, 2013 DME
>Competitive Bidding letter. Responses have also gone out to the other
>cosigners of the letter. Thanks.

>

>Al Chadwick
>Office of Legislation/Congressional Affairs Group Centers for Medicare
>& Medicaid Services
>200 Independence Ave, SW
>Room 351G
>Washington, DC 20201
>202-690-5519 (Phone)
>202-690-8168 (Fax)
>alpheus.chadwick@cms.hhs.gov
>

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Tuesday, July 2, 2013 3:39 PM
To: Price, Tom (Amanda Street)
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Meeting w/ Dir. Tavenner

Hello Amanda,

Marilyn Tavenner, CMS Administrator, is happy to meet with Rep. Price, but she's traveling this week and next week; therefore, we would like to set something up for the last week of July. I look forward hearing back from you.

-Al

From: Street, Amanda [<mailto:Amanda.Street@mail.house.gov>]
Sent: Tuesday, July 02, 2013 11:55 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Meeting w/ Dir. Tavenner

Hi Al,

Thank you so much for getting in touch in regards to our request for a meeting between Dr. Price and Director Tavenner. Dr. Price has a number of issues he'd like to talk about, and would enjoy the opportunity to share his thoughts and concerns. The Congressman would like to establish an open line of communication between the two of them and would enjoy meeting in person as well. He would be happy to meet with the Director at her office or his own office.

If the Director is available to talk this week, the Congressman would like to schedule a call (he would prefer video call if that's an option) to discuss competitive bidding, QIOs, and FFS proposed rule that is due to come out shortly. If this is not possible due to the Director's schedule, perhaps we can schedule something for next week.

Al, many thanks for all your help in this matter.

Best wishes,

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

Chadwick, Alpheus K. (CMS/OL)

From: Street, Amanda <Amanda.Street@mail.house.gov>
Sent: Tuesday, July 2, 2013 11:55 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Meeting w/ Dir. Tavenner

Hi Al,

Thank you so much for getting in touch in regards to our request for a meeting between Dr. Price and Director Tavenner. Dr. Price has a number of issues he'd like to talk about, and would enjoy the opportunity to share his thoughts and concerns. The Congressman would like to establish an open line of communication between the two of them and would enjoy meeting in person as well. He would be happy to meet with the Director at her office or his own office.

If the Director is available to talk this week, the Congressman would like to schedule a call (he would prefer video call if that's an option) to discuss competitive bidding, QIOs, and FFS proposed rule that is due to come out shortly. If this is not possible due to the Director's schedule, perhaps we can schedule something for next week.

Al, many thanks for all your help in this matter.

Best wishes,

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

Chadwick, Alpheus K. (CMS/OL)

From: Street, Amanda <Amanda.Street@mail.house.gov>
Sent: Thursday, August 29, 2013 2:48 PM
To:
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: Tavenner

I apologize for taking so long to get back to you. I have been in the district traveling for the past two weeks and had very limited access to my email.

I think it would be a great idea for him to try to get a meeting scheduled.

If you choose to go the CMS route as well, here is the email address for my contact at CMS, Al Chadwick:

Alpheus.Chadwick@cms.hhs.gov

I have spoken with Al and he would like me to pass your information along to him. Would you prefer me to wait to do that?

I'm still working to get the lead Dem finalized with Elizabeth from Rep. Kind's office. I've received interest from Rep. Ruppertsberger.

I never heard from Shane Lieberman in Buchanan's office though.

I have not had a chance to edit the letter yet, but I will be getting to it shortly.

Again, my apologies for the delay in getting back to you. I hope all of this information is helpful.

Best wishes,

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

From:
Date: Thursday, August 22, 2013 2:50 PM
To: Rep Tom Price <Amanda.Street@mail.house.gov>
Subject: Tavenner

Amanda –

Our president recently spoke with

Apparently he has a relationship with Tavenner. Would it be a good idea for him to try to facilitate a meeting as well or would it just confuse things?

Best,

Chadwick, Alpheus K. (CMS/OL)

From: Street, Amanda <Amanda.Street@mail.house.gov>
Sent: Thursday, September 5, 2013 11:06 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: Help scheduling a meeting

Hi Al,

I hope this email finds you well and I hope you enjoyed the long Labor Day weekend. I apologize for taking so long to get back to you with regards to scheduling meetings.

As I recall, we spoke on a number of issues: a potential meeting with the Administrator, a potential meeting with a member of staff, and working to schedule a meeting AAHKS/AAOS.

I believe it would be very helpful for me to meet with a member of staff in order to discuss further the QIO program and home health. However, Congressman Price would still prefer to have the opportunity to follow up with Administrator Tavenner on the issues previously discussed.

Thank you for your assistance in scheduling a meeting between AAHKS/AAOS and the Administrator. Below you will find the requested contact information for AAHKS/AAOS:

Thank you for all your help and have a wonderful day!

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

From: <Chadwick>, "Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov>
Date: Tuesday, August 20, 2013 9:17 AM
To: Rep Tom Price <Amanda.Street@mail.house.gov>
Cc: "Howell, Cherie A. (CMS/OL)" <Cherie.Howell@cms.hhs.gov>
Subject: RE: Help scheduling a meeting

Hi Amanda,

Please give me a call when you have a moment this morning to discuss the scheduling of these meetings. Thanks.

Al Chadwick
Office of Legislation/Congressional Affairs Group
Centers for Medicare & Medicaid Services
200 Independence Ave, SW
Room 351G
Washington, DC 20201
202-690-5519 (Phone)
202-690-8168 (Fax)
alpheus.chadwick@cms.hhs.gov

From: Street, Amanda [<mailto:Amanda.Street@mail.house.gov>]
Sent: Friday, August 16, 2013 7:27 AM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Howell, Cherie A. (CMS/OL)
Subject: Re: Help scheduling a meeting

Hi Al,

I will still be in the district next week and my schedule on Monday is very full. Would it be possible for us to chat on Tuesday, August 20th, at 9am?

Many thanks and have a great weekend!

Best,
Amanda
Sent from my iPhone

On Aug 15, 2013, at 4:47 PM, "Chadwick, Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov> wrote:

Hi Amanda,

I tried calling, but understand you are in the district. Since I'm out of the office until Monday, let's connect then to discuss this follow-up request. I hope you are enjoying yourself and the time away. Thx.

-Al

From: Street, Amanda [mailto:Amanda.Street@mail.house.gov]

Sent: Friday, August 02, 2013 11:41 AM

To: Chadwick, Alpheus K. (CMS/OL)

Subject: Help scheduling a meeting

Hi Al,

I want to thank you again for all your help in scheduling the meeting for Congressman Price and Administrator Tavenner. I believe it was a beneficial conversation for both and the start of a positive working relationship. One of the takeaways from that meeting was to try to reconnect after the August recess. Could you help us schedule a meeting for the second or third week of September between the Congressman and Administrator?

Administrator Tavenner also mentioned that Patrick (she didn't provide a last name) might be able to attend the meeting as well to provide input about QIOs and the future of FFS payments.

One of the issues discussed during the meeting was proposed cuts to hip and knee arthroplasty. Administrator Tavenner encouraged those doctors and organizations interested in providing comments on the proposed cuts to hip/knee arthroplasty to do so in the coming weeks. What would be the best avenue to do so?

Administrator Tavenner also expressed her willingness to meet with these organizations. AAHKS and the American Association of Orthopedic Surgeons (AAOS) would like the opportunity to meet with Administrator Tavenner, at her convenience. Could you help facilitate that or is there someone else I should put them in contact with?

Again, thank you for all your help, Al!

Best wishes,

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

Chadwick, Alpheus K. (CMS/OL)

From: Street, Amanda <Amanda.Street@mail.house.gov>
Sent: Wednesday, November 20, 2013 10:32 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: Re: W&M Hearing Follow-up

Hi Al,

Thank you for getting us a response to that question.

Best wishes,

Amanda Street
Congressman Tom Price, MD
100 Cannon House Office Building
Washington, DC 20515
202-225-4501

From: <Chadwick>, "Alpheus K. (CMS/OL)" <Alpheus.Chadwick@cms.hhs.gov>
Date: Tuesday, November 19, 2013 5:41 PM
To: Rep Tom Price <Amanda.Street@mail.house.gov>
Subject: W&M Hearing Follow-up

Hello Amanda,

I'm writing to follow up on the question your boss asked Administrator Tavenner at the W&M hearing on October 29th, 2013. His question was about a particular line of source code on HealthCare.gov. The language he referenced is standard boiler-plate language for federal websites that was in our source code and has since been removed.

Al Chadwick
Office of Legislation/Congressional Affairs Group
Centers for Medicare & Medicaid Services
200 Independence Ave, SW
Room 351G
Washington, DC 20201
202-690-5519 (Phone)
202-690-8168 (Fax)
alpheus.chadwick@cms.hhs.gov

Chadwick, Alpheus K. (CMS/OL)

From: Poole, Jennifer <Jennifer.Poole@mail.house.gov>
Sent: Monday, December 30, 2013 10:46 AM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Tyler Jones/Obamacare concern

I don't....I'm just getting back in town.

Do you still need one?

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Tuesday, December 17, 2013 11:35 AM
To: Poole, Jennifer
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Tyler Jones/Obamacare concern

Hi Jennifer – do you have an email address for ..just checking? Thx.

-Al

From: Poole, Jennifer [mailto:Jennifer.Poole@mail.house.gov]
Sent: Thursday, December 12, 2013 12:19 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Tyler Jones/Obamacare concern

Ok, just spoke to him. He never received an application #. The site would always say "pending". He just wants all of his personal information taken out and deleted.

From: Poole, Jennifer
Sent: Thursday, December 12, 2013 12:00 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: RE: Tyler Jones/Obamacare concern

checking on this...thx!

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Thursday, December 12, 2013 11:52 AM
To: Poole, Jennifer
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Tyler Jones/Obamacare concern

Also, do you have an application number for

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Thursday, December 12, 2013 11:47 AM
To: Poole, Jennifer
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Tyler Jones/Obamacare concern

Hello Jennifer – I will ask that his application is deleted.

-Al

From: Poole, Jennifer [mailto:Jennifer.Poole@mail.house.gov]
Sent: Wednesday, December 04, 2013 1:34 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Tyler Jones/Obamacare concern

Dear Al,

Thanks for this information. This is comforting since I have to sign up as well.

is adamant about not wanting his application processed. He wants the entire application deleted. Is this possible?

Thank you again for your kind assistance!

Jennifer

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Tuesday, November 26, 2013 4:09 PM
To: Poole, Jennifer
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Tyler Jones/Obamacare concern

Hello Jennifer,

I was asked to follow-up on your note regarding _____ and his concerns regarding is personal identifiable information on healthcare.gov. CMS developed the data services Hub and Federally-facilitated Marketplace eligibility and enrollment system consistent with Federal statutes, guidelines and industry standards that ensure the security, privacy, and integrity of systems and the data that flows through them. All of CMS' IT systems—including Federal Marketplace systems of records and systems used to support State-based Marketplaces and Medicaid/CHIP agencies—are subject to the Privacy Act of 1974, the Computer Security Act of 1987, and the Federal Information Security Management Act of 2002 (FISMA). These systems must also comply with various rules, regulations, and standards promulgated by the Department of Health and Human Services (HHS), the Office of Management and Budget, the Department of Homeland Security, and the National Institute of Standards and Technology (NIST). The authorization to operate the Federally-facilitated Marketplace eligibility and enrollment system is consistent with NIST guidance. The Hub and the Federally-facilitated Marketplace eligibility and enrollment system have **several layers of protection** in place to mitigate information security risk. For example, these Marketplace IT systems will employ a **continuous monitoring model** that will utilize sensors and active event monitoring to quickly identify and take action

against irregular behavior and unauthorized system changes that could indicate a potential incident.

I hope this helps.

-AJ

From: Poole, Jennifer
Sent: Tuesday, November 12, 2013 1:07 PM
To: 'roatlora@cms.hhs.gov'
Subject: Tyler Jones/Obamacare concern

Dear friends,

_____ has contacted Congressman Price concerning a problem with Obamacare. For your reference, we have included a copy of his correspondence with our office.

We would appreciate your providing us with any information you feel may address his concerns.

Thank you for your attention to this matter. We look forward to hearing from you.

Sincerely,

Jennifer Poole
Director of Constituent Services
Office of Congressman Tom Price, M.D.
85-C Mill Street, Suite 300
Roswell, GA 30075
770-998-0049
770-998-0050 fax

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Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Monday, January 4, 2016 4:09 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Letter re: CCJR from Congressman Price (60 Members total)

Thanks again, Al.

Happy New Year!

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Wednesday, December 16, 2015 9:40 AM
To: DiBlasio, Carla
Cc: Zebley, Kyle; Howell, Cherie A. (CMS/OL)
Subject: RE: Letter re: CCJR from Congressman Price (60 Members total)

Good Morning Carla –

Please see the response attached.

-Al

From: DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]
Sent: Tuesday, December 15, 2015 7:24 PM
To: Howell, Cherie A. (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Cc: Zebley, Kyle
Subject: RE: Letter re: CCJR from Congressman Price (60 Members total)

Hi Al,

Chairman Price has not received a response from CMS for his letter regarding the CCJR bundled payment model. The letter is dated September 21, 2015. Sixty Members of Congress signed the letter. When can we expect a response to this letter?

Thanks so much,
Carla

Carla DiBlasio, Esq.
Policy Advisor

Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: DiBlasio, Carla
Sent: Wednesday, September 23, 2015 9:38 AM
To: 'Howell, Cherie A. (CMS/OL)'
Cc: Beck, Gary; Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Letter re: CCJR from Congressman Price (60 Members total)

Many thanks!

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Howell, Cherie A. (CMS/OL) [<mailto:Cherie.Howell@cms.hhs.gov>]
Sent: Wednesday, September 23, 2015 9:11 AM
To: DiBlasio, Carla
Cc: Beck, Gary; Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Letter re: CCJR from Congressman Price (60 Members total)

Good Morning,
I have sent this for response. I have cc:ed Al Chadwick, your congressional liaison for Georgia.

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Tuesday, September 22, 2015 7:34 PM
To: Howell, Cherie A. (CMS/OL)
Cc: Beck, Gary
Subject: Letter re: CCJR from Congressman Price (60 Members total)

Hi Cherie,

Attached please find a letter to the Secretary led by Congressman Price. It is signed by 60 Members of Congress. Can you please see that this letter gets to the right hands?

Thank you in advance for your assistance.

Best,
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building

Washington, DC 20515 | 202.225.4501





DEC - 2 2015

Administrator
Washington, DC 20201

The Honorable Tom Price, MD
U.S. House of Representatives
Washington, DC 20515

Dear Representative Price:

Thank you for your interest in and feedback on the Comprehensive Care for Joint Replacement (CJR) Model. This payment, quality, and care improvement initiative takes a major step forward in the Administration's commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way. The model will hold hospitals accountable for the costs and quality of care furnished to Medicare beneficiaries for hip and knee replacements from surgery through recovery.

After reviewing and considering nearly 400 comments from the public on the proposed rule for the CJR Model, we issued the final rule on November 16, 2016. The CJR Model includes several revised policies in the final rule that are designed to afford hospitals and their partners in care delivery adequate time to prepare for success under the model prior to the start date. The final policies are listed and described below.

- **Delayed Start Date:** In order to allow participant hospitals more time to prepare for success under the model, the first performance period for the model will begin on April 1, 2016, instead of the proposed January 1, 2016 performance period start date.
- **Financial Protections:** In response to comments from the public, we have finalized additional policies to phase in financial responsibility for hospitals participating in the CJR Model. Hospitals will have no repayment responsibility in Performance Year (PY) 1, and repayment responsibility will be phased in gradually over the course of PYs 2 and 3. The final rule also includes stop-loss protections limiting the amount of financial responsibility for all participant hospitals, with additional financial protection for certain types of participant hospitals, such as rural hospitals or sole community hospitals. The stop-loss protections in the final rule also follow a more gradual implementation timeline than those in the proposed rule, with a stop-loss limit of 5 percent in PY 2, 10 percent in PY Year 3, and 20 percent in PYs 4 and 5.
- **Data Sharing:** The CJR Model will provide all participant hospitals with the opportunity to request robust data to aid them in identifying opportunities for care redesign and savings and to identify appropriate clinical partners. Such data will provide

participants in the model with the information necessary to identify opportunities for care redesign and evaluate their current care patterns.

- Utilizing Existing Payment Processes: The usual Medicare Fee-or-Service claims submission processes will continue throughout the model. In other words, providers and suppliers furnishing services during the episode of care will submit a claim to Medicare and receive payment as they normally would.
- Accounting for Complex Patients: The CJR Model has been designed to include appropriate safeguards for complex patients, including a payment method that protects hospitals from the risk of high payment episodes. In addition, in response to commenters' requests to modify our payment structure to account for more complex patients, we finalized a risk stratification method that will set different prices for beneficiaries undergoing lower joint replacement procedures due to hip fracture.

We have also finalized the following proposals to protect beneficiaries: additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services; and continued protection of patient data under the Health Insurance Portability and Accountability Act of 1996 (and other applicable privacy laws; and patient notification by providers and suppliers. Further, beneficiaries retain their freedom of choice to choose services and providers, and all existing safeguards to protect beneficiaries and patients will remain in place. If a beneficiary believes that his or her care has been adversely affected, he or she can call 1-800-MEDICARE or contact his or her state's Quality Improvement Organization. If concerns are identified, the Centers for Medicare & Medicaid Services can initiate audits and corrective action under existing authority.

Participating hospitals meeting certain criteria, such as rural hospitals, Medicare-dependent hospitals, and sole community hospitals, will be afforded additional financial protections for the duration of the model. We will implement a stop-loss limit of 3 percent of episode payments for these categories of hospitals in PY 2 and a stop-loss limit of 5 percent of episode payments for PYs 3 through 5.

Under existing bundled payment models, in which providers across the continuum of care share accountability for the clinical management and total cost of an episode of care, the capacity to share information electronically across disparate provider systems can be important for delivering efficient, safe, high-quality care. With respect to the utilization of electronic health records (EHRs) by participant hospitals and their clinical partners in the CJR Model, we received comments from the public on an EHR usage measure in the proposed rule. We appreciate the insights and concerns expressed around utilizing a measure of health information technology tied to participation in EHR incentive programs. We will consider these comments as we assess any future measures for the CJR model.

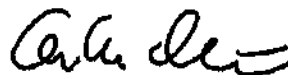
Finally, we note that while participant hospitals will be the episode initiators under this model and the entities financially responsible, the model will allow participant hospitals to enter into

Page 3 - The Honorable Tom Price, MD

financial arrangements with collaborating providers and suppliers who are engaged in care redesign with the hospital and who furnish services to the beneficiary during an episode. Under these arrangements, a participant hospital may share payments received from Medicare as a result of reduced episode spending and hospital internal cost savings with collaborating providers and suppliers, subject to parameters outlined in the rule. Our experience with other episode payment models has demonstrated that many providers view these arrangements to be useful mechanisms in better aligning financial incentives between different provider types. That said, we believe it is necessary to have a limit on the maximum amount a collaborating provider or supplier could earn through these arrangements to ensure that distributions are not made for purposes other than improving the quality and value of care to beneficiaries. In addition to sharing savings, participant hospitals may also share financial accountability for increased episode spending with collaborating providers and suppliers. Finally, participant hospitals may provide beneficiaries with certain incentives to advance the clinical goals of their care, under certain conditions.

Thank you for your feedback on the CJR Model. We look forward to continuing to partner with you to achieve better care, smarter spending, and healthier people. We look forward to engaging further on this important initiative. I will also provide this response to the co-signers of your letter.

Sincerely,



Andrew M. Slavitt
Acting Administrator

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Sent: Wednesday, January 20, 2016 8:28 PM
To: Druckman, Jennifer (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Cc: Dugan, Meghan
Subject: RE: Question re: the passage of S. 2425

Good evening,

Chairman Tom Price would like to request a phone call with Mr. Andy Slavitt to discuss the implementation of S. 2425, including when physicians can expect to see guidance on this. He is very concerned about the fact that physicians now have less than 60 days to submit a hardship application under the March 15th deadline for the new streamlined hardship application process.

The phone call should not take long, so many thanks for your assistance in setting this up. I've copied our scheduler, Meghan Dugan, who will be able to help confirm a time.

Many thanks!
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: DiBlasio, Carla
Sent: Tuesday, January 12, 2016 2:12 PM
To: 'Druckman, Jennifer (CMS/OL)'
Cc: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: Question re: the passage of S. 2425

Good Afternoon,

Pursuant to [S. 2425](#) being signed into law by the President on December 28th, CMS was granted additional authority to offer hardship exemptions to participants in the Meaningful Use Program (Medicare & Medicaid EHR Incentive Program).

The law institutes new opportunities for physicians and hospitals to apply for hardship exemptions and imposes new deadlines for these opportunities. To be able to maximize the important flexibility created by this law, it's imperative that the necessary guidance for program participants be released as soon as possible. Could you provide any update on when we can expect the guidance for participants to be released? When will CMS' updated website be ready for use (in applying for a hardship exemption)? How does CMS anticipate informing the provider community about how to leverage the new hardship exemption pathways?

As you know, the first submission deadline is March 15th, therefore we hope CMS can issue guidance to allow for at least 60-days for providers to prepare their applications.

Many thanks!
Carla

Carla DiBiasio, Esq.
Policy Advisor

Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Sent: Friday, February 5, 2016 8:18 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Martino, Maria (CMS/OL)
Subject: RE: TIME SENSITIVE re: Brookwood Nursing Center, Inc

Thanks Al,

I really appreciate your response this afternoon.

Have a wonderful weekend,
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Friday, February 05, 2016 4:23 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: RE: TIME SENSITIVE re: Brookwood Nursing Center, Inc

Hello Carla – I want to address the questions in your note below.

- 1) Did the facility know of the deficiencies;
A: The facility was notified on January 26, 2016 regarding identification of ongoing immediate jeopardy.
- 2) Did the facility have a year to correct the deficiencies;
A: The survey was completed January 15, 2016 The recertification survey identified non-compliance dating back to January 31, 2015.
- 3) What were the actual deficiencies at issue in January 2015 that were ongoing and not corrected?
A: The immediate jeopardy citations were related to staff treatment of residents, neglect & abuse, pressure ulcers and accident hazards.

Furthermore, a revisit was conducted on February 3, 2016 and the immediate jeopardy was not abated, it is ongoing. As a result, the termination will go into effect.

-Al

From: DiBlasio, Carla [mailto:Carla.Diblasio@mail.house.gov]
Sent: Friday, February 5, 2016 1:11 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: TIME SENSITIVE re: Brookwood Nursing Center, Inc
Importance: High

Alpheus,

I hope this email finds you well. Congressman Price has been contacted about the pending removal of

In the letter from CMS dated January 26, 2016, it states *"On January 15, 2016, a recertification/extended survey was completed at Brookwood Nursing Center, Inc., The immediate jeopardy was identified to exist on **January 31, 2015**, and is considered ongoing."*

- Can you confirm the original certification survey was completed in **January 2015** and 1) the facility knew of the deficiencies; 2) the facility has had a year to correct the deficiencies; and 3) what were the actual deficiencies at issue in January 2015?

Nonetheless, we request that you provide Brookwood Nursing Center a 10-day extension to fulfill all obligations and demonstrate total compliance within 10 days. The removal of Brookwood Medicare/Medicaid residents on February 7th is a serious disruption of care. Additionally, relocating patients will lead to inaccessibility for the families of Brookwood residents due to the current lack of beds in nearby facilities.

Thank you for your assistance. Any information you can provide today would be greatly appreciated.

Carla DiBlasio

Carla DiBlasio, Esq.
Policy Advisor

Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



Brooke McGee

From:
Sent: Thursday, February 04, 2016 4:18 PM
To: Brooke McGee
Subject: Fwd: Help

Begin forwarded message:

From:
Date: February 4, 2016 at 2:48:18 PM EST
To: tom price <pricet6@gmail.com>
Subject: Help

I need major help . I have a 88 bed nursing home in Decatur tenn. I have owned and operated it for over 20 years with no issues or problems . Jan 15 the state surveyor team came in for our annual inspection. They immediately discovered w had an issue with falls and put us in immediate jeopardy. We had 10 ij tags all related to falls and the fine is over \$800,000 and they gave us till February 7 to be back in compliance . The paperwork received was over 150 long . We have had a Corp team at the facility since then and our plan of correction was submitted and excepted by the state . We have worked diligently to be back in compliance . The state came back in Monday and this morning we were notified that we are still not in compliance and we would loose our Medicare funding feb 7th. We further understand we will be notified that the same will happen with Medicaid . We are licensed for 88 beds . We have 5 Medicare and 55 Medicaid patients today . This whole process has been in 20 days . The Cms letter says we have a right to appeal but they say we loose certification feb 7. We talked with them today asked for more time . They said no . We understand they are going to notify patients Sunday to start moving . We totally disagree that the home is in jeopardy . We have not had an injury and the patients are being cared for totally . These are all administrative problems which is taking time . It is vertically impossible to have this corrected within the time period they say . Patients are not at risk . Our attorney says to call our congressman at my home and at the facility home . That is Scott ?? He is aware of this type of issues I understand but not aware this is happening to us in his district . I will call him now but he does not have a email address . I really need your help my friend . This will be devastating to our patients and me. I can't think of Scott's name but I will get it . Please help . Thanks

PRIVACY RELEASE FORM
Congressman Tom Price, M.D.
Sixth Congressional District of Georgia

Date: 2-4-16

Once complete, please return it to:

Office of Congressman Tom Price, M.D.
85-C Mill Street, Suite 300
Roswell, GA 30075
770-998-0050 Fax

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909



Refer to: 44-5278.IJ ongoing. 01.26.16

IMPORTANT NOTICE – PLEASE READ CAREFULLY
SENT VIA FEDEX AND INTERNET E-MAIL
(Receipt of this notice is presumed to be January 26, 2016 – Date notice e-mailed)

January 26, 2016

A facility must meet the pertinent provisions of Sections 1819 and 1919 of the Social Security Act and be in substantial compliance with each of the requirements for long-term care facilities, established by the Secretary of Health and Human Services in 42 C.F.R. section 483.1 *et seq.*, in order to qualify to participate as a skilled nursing facility in the Medicare program and as a nursing facility in the Medicaid program.

On January 15, 2016, a recertification/extended survey was completed at Brookwood Nursing Center, Inc., by the East Tennessee Regional Office of Health Care Facilities (SSA) to determine if your facility was in compliance with the Federal requirements for long-term care facilities participating in the Medicare and Medicaid programs. **The survey found that your facility was not in substantial compliance with the participation requirements, and that conditions in your facility constituted immediate jeopardy to residents' health and safety and substandard quality of care. The immediate jeopardy was identified to exist on January 31, 2015, and is considered ongoing. A statement of the deficiencies (CMS-2567) was furnished to you by the Tennessee State Survey Agency with a letter dated January 20, 2016.**

All regulatory requirements and references contained in this letter are found in Title 42, Code of Federal Regulations.

Your request for an Independent IDR should be sent to this office and the following address:

Victoria Stedman, RN
IDR Coordinator
Division of Health Care Facilities
665 Mainstream Drive, Second Floor,
Nashville, TN 37243
Phone # (615) 741-7493

Please note that an incomplete Independent IDR process will not delay the effective date of any enforcement remedy imposed on your facility, and it will not delay our collection of your facility's CMP for more than ninety (90) days.

We are authorized by federal law at 42 C.F.R. 488.431(b) to collect your CMP in 90 days and place it in escrow, or to do so when a decision is issued from an Independent IDR proceeding, whichever is earlier.

Please note, furthermore, that an incomplete IDR or Independent IDR process will not delay any deadline listed below under "Appeal Rights" for requesting a hearing, or for requesting a waiver of hearing rights.

NOTICE OF RIGHT TO REQUEST HEARING OR WAIVE HEARING RIGHTS

As explained more fully below under "Appeal Rights," you have the right to request a hearing before the Departmental Appeals Board (DAB) if you wish to dispute the basis and amount of your facility's CMP. You also may decide to waive your right to a hearing, in accordance with regulations at 42 C.F.R. 488.436. If you would like to waive your right to a hearing, you must do so in writing within sixty (60) days of receiving this notice. If you waive your right to a hearing, the amount of your CMP will be reduced by thirty-five percent (35%); on the other hand, if you request a hearing or miss the deadline for requesting a waiver, your CMP will not be reduced by 35 percent. You must submit your waiver request directly to our Atlanta Regional Office by certified mail or via Internet e-mail to the CMP Waiver mail box. The Atlanta Regional Office does not accept CMP waivers via facsimile. CMP waivers on company letterhead may be submitted via Internet e-mail to the CMP Waiver mail box. The Internet e-mail address is:

CMPWaiversATL@cms.bhs.gov

• **Discretionary Denial of Payment for New Admissions (DPNA)**

Discretionary Denial of Payment for New Admissions is effective January 28, 2016, if your facility is still out of compliance on that date.

Please note that filing of Medicare or Medicaid claims for new admissions after the denial of payment for new admissions (DPNA) is in effect could result in such claims being considered "false" claims under applicable federal statutes and thus potentially subjecting the filing entity to a referral to the appropriate authorities and possibly to the penalties prescribed under such

Remedies Imposed

We have reviewed the January 15, 2016 survey findings, and the State Survey Agency's recommendations, and we are imposing the following mandatory and discretionary enforcement remedies on the dates indicated:

I. MANDATORY REMEDIES

• Mandatory Termination

In accordance with federal law at 42 C.F.R. 488.410, we must terminate the Medicare provider agreement of a facility within twenty-three (23) days after a survey reveals conditions constituting immediate jeopardy. **Immediate jeopardy was identified during your facility's survey on January 15, 2016, and the termination of your Medicare provider agreement will become effective February 7, 2016, if we cannot confirm before that date the abatement of conditions constituting immediate jeopardy.** We are required to provide the general public with a notice of impending termination, and will publish a notice in your local newspaper prior to the effective date of the termination.

II. DISCRETIONARY REMEDIES

• Civil Money Penalty (CMP)

As a result of your facility's noncompliance as evidenced by the findings of the January 15, 2016 survey, and in accordance with sections 1819 (h) and 1919 (h) of the Social Security Act and the enforcement regulations specified at 42 C.F.R. Part 488, **we are imposing a CMP in the amount of \$4,050.00 per day effective July 5, 2015, which will continue to accrue either until substantial compliance is achieved or your facility's Medicare participation is terminated.** We considered factors identified at 42 C.F.R. 488.438 (f) in setting the amount of the CMP. The amount of the CMP may be increased if we find that noncompliance continues and/or worsens.

NOTICE OF INTENT TO HOLD YOUR FACILITY'S CMP IN ESCROW

In accordance with federal law at 42 C.F.R. 488.431 and based on the scope/severity of noncompliance identified during your facility's survey, we have decided to collect your facility's CMP and place it in an escrow account. If you wish to dispute the findings of noncompliance upon which we have made this decision, you may request an Independent Informal Dispute Resolution (Independent IDR) proceeding in accordance with 42 C.F.R. sections 488.331 and 488.431. **If you would like to request an Independent IDR, you must do so in writing within ten (10) days of receiving this notice.** Your written request should identify the specific findings of noncompliance you are disputing, as well as an explanation of why you are disputing them and/or why you are disputing the scope/severity of noncompliance constituting immediate jeopardy or substandard quality of care.

statutes. An exception possibly applies where a timely appeal of the controlling certification/finding of noncompliance is filed (and remains pending) under 42 C.F.R. Part 498, and where your facility has made arrangements acceptable to your Medicare Administrative Contractor to submit the claim (or claims) with prominent flagging clearly indicating that the claim(s) is/are being filed not for current payment, but "under protest" and for the sole purpose of preserving a timely filing should the facility prevail on its administrative appeal under 42 C.F.R. Part 498. **"Please note that the Denial of Payment for New Medicare Admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions."**

Allegation of Compliance (AoC)/Plan of Correction (PoC)

Within five (5) days of your facility's receiving its statement of deficiencies (Form CMS-2567), you must submit in writing a credible allegation for removal of immediate jeopardy and/or a Plan of Correction (POC) regarding all noncompliance identified in the Form CMS-2567. Failure to submit an acceptable, credible allegation and/or POC within the 5-day time limit may result in the termination of your Medicare provider agreement, in accordance with 42 C.F.R. 488.456(b). You should submit your credible allegation and/or POC to the Tennessee State Survey Agency.

Substandard Quality of Care (SOC)

Your facility's noncompliance with 42 C.F.R. 483.13, F224K, F225K and 42 C.F.R. 483.25, F314K, and F323K have been determined to constitute substandard quality of care (SOC) as defined at 42 C.F.R. 488.301. Sections 1818(g)(5)(C) and 1919 (g)(5)(C) of the Social Security Act, as well as implementing regulations at 42 C.F.R. 488.325(h), require the State Survey Agency to send written notice of your facility's SOC to the attending physician of each resident, as well as the state board responsible for licensing the facility's administrator. In order to satisfy these notification requirements, you are required to provide the State Survey Agency with the name and address of the attending physician for each resident found to have received SOC. The State Survey Agency will advise you of the deadline for providing this information. Please note that, in accordance federal law at 42 C.F.R. 488.325(g), your failure to provide this information in a timely fashion will result in the termination of your facility's Medicare provider agreement, or the imposition of alternative remedies.

Staff treatment of Residents

Due to your facility's current noncompliance with F224 and F225, CMS would like to emphasize the importance of corrective actions to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated and must act to prevent further potential abuse while the investigation is in progress. We ask that you carefully monitor your facility's compliance with Federal requirements. Please consider contacting the Quality Improvement Organization (QIO) in your state for information and training opportunities. Also, we ask that you consider using the Hand in Hand Training Module, when providing training to your staff in giving better care to persons with dementia, in understanding and preventing abuse, and in giving person-centered care to all residents. If noncompliance continues in this area, progressive enforcement remedies will be imposed.

Pressure Ulcers

Due to your facility's noncompliance with F314, pressure ulcers, we would like to emphasize the importance of corrective actions that ensure that avoidable pressure ulcers will not occur at your facility and that residents will receive appropriate care and services to prevent the increase in complexity of existing pressure ulcers. The pain, infection rates, and increased morbidity and mortality associated with pressure ulcers underscore the need for your facility to improve its systems for identifying residents at risk and for implementing preventive services. We ask that you carefully monitor your facility's compliance with Federal requirements related to the prevention of pressure ulcer development. Please consider contacting the Quality Improvement Organization (QIO) in your state for information and training opportunities on pressure ulcer care and prevention. If noncompliance continues in this area, more severe remedies will be imposed.

Loss of Nurse Aide Training Program (NATCEP)

Please note that federal law in the Social Security Act at sections 1819 (f)(2)(B) and 1919 (f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) offered by a facility which within the previous two years has operated under a section 1819 (b)(4)(c)(ii)(II) or section 1919 (b)(4)(ii) waiver; has been subject to an extended or partial extended survey; has been assessed a civil money penalty of \$5,000 or more; or, has been subject to denial of payment, the appointment of a temporary manager, termination or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. As a result of your facility's noncompliance, these NATCEP provisions are applicable to your facility. You will receive further notification from the State agency responsible for such matters.

Appeal Rights

If you disagree with enforcement remedies imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building - Room G-644
Washington, D.C. 20201

Alternatively, you may file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab/efile.hhs.gov>. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Region4 DAB HearingRequest@cms.hhs.gov

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense.

If you have any questions regarding this matter, please contact Bessie Barnes by phone at (404) 562-7442 or by e-mail at bessie.barnes@cms.hhs.gov.

Sincerely,

Stephanie M. Davis

for:

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

Enclosure

cc: State Survey Agency
State Medicaid Agency
LTCE Branch Manager
Medicare Administrative Contractors
HUD, Office of Healthcare Programs
Medicare Advantage Branch

How to Use the Departmental Appeals Board's Electronic Filing System (DAB E-File)

<https://dab.efile.hhs.gov>

To file a new appeal using DAB E-File, you first must register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative handling your appeal, each representative must register separately to use DAB E-File on your behalf.

How to log-in to DAB E-File. To access DAB E-File, the e-mail address and password provided during the registration process must be entered on the **Login** screen at https://dab.efile.hhs.gov/user_sessions/new. A registered user's access to DAB E-File is restricted to the appeals for which s/he is a party or authorized representative.

How to file an appeal (request for hearing) in DAB E-File. After you have registered and logged-in to DAB E-File, you may file an appeal by: (A) clicking the **Manage Existing Appeals** button, then at the next page clicking the **File New Appeal** link, then at the next page clicking the **Civil Remedies Division** button; then (B) entering and uploading the requested information and documents on the form labeled "File New Appeal – Civil Remedies Division."

Basic requirements for using DAB E-File. At a minimum, the DAB's Civil Remedies Division (CRD) requires a party filing an appeal to submit the following: (1) a signed hearing request; and (2) a copy of the underlying notice letter from CMS which sets forth CMS's adverse action and the party's appeal rights. All documents must be submitted in Portable Document Format (PDF). Any document, including a hearing request, will be deemed to have been filed on the date it is submitted via DAB E-File (through 11:59 p.m. EST on the date of submission). A party filing a hearing request via DAB E-File will be deemed to have consented to receiving and accepting electronic service of appeal-related documents which CMS subsequently submits via DAB E-File and/or which the CRD subsequently submits via DAB E-File on behalf of an Administrative Law Judge. CMS also will be deemed to have consented to electronic service.

Detailed information regarding DAB E-File. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Monday, February 8, 2016 6:19 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Zebley, Kyle
Subject: Two Medicare Letters from Congressman Tom Price
Attachments: LCD cardiovascular biomarkers_2-8-16.pdf; Consignment Closets DME Issue.pdf

Al,

Please find attached two letters to CMS signed by Chairman Price. Let me know if you have any questions. We appreciate your attention to both matters.

Kind regards,
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



TOM PRICE, M.D.
6TH DISTRICT, GEORGIA

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www.house.gov/tomprice



COMMITTEE ON THE BUDGET
CHAIRMAN

COMMITTEE ON WAYS AND MEANS

Congress of the United States House of Representatives

February 8th, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Acting Administrator Slavitt,

I am writing to express concern about the Local Coverage Determination (LCD) ModDX: Biomarkers in Cardiovascular Risk Assessment (DL36358), which is currently under review in numerous Medicare Administrative Contractor (MAC) jurisdictions. This policy would discontinue coverage for most cardiovascular risk assessment diagnostics. If finalized, this policy will deny physicians and Medicare beneficiaries access to life-saving cardiovascular risk assessment tools and raise costs for the Medicare program.

Often called the “silent killer,” cardiovascular disease is our nation’s leading cause of death. According to data from Johns Hopkins, 84 million people in the United States suffer from some form of cardiovascular disease, causing approximately 2,200 deaths a day, or one death every 40 seconds. One out of three deaths in the United States is the result of cardiovascular disease, and the direct and indirect costs of cardiovascular disease and stroke are about \$315 billion annually—a number that is increasing each year.¹

Complicating the issue, the traditional indicators of cardiovascular disease risk, like the 50 year-old lipid panel, are now known to detect such risk in only a subset of patients. In fact, the majority of people who suffer heart attacks and stroke have “normal” lipid panel values. Fortunately, researchers and clinicians have developed additional diagnostic tests to much more accurately identify cardiovascular risk. For example, peer-reviewed research has demonstrated that the presence of atherogenic plaque is an indicator of cardiovascular disease.^{2,3} For the

¹ *Cardiovascular Disease Statistics*, JOHNS HOPKINS MEDICINE, http://www.hopkinsmedicine.org/healthlibrary/conditions/cardiovascular_diseases/cardiovascular_disease_statistics_85,P00243/.

² Brilakis ES et al., *Association of Lp-PLA2 levels with coronary artery disease risk factors, angiographic coronary artery disease and major adverse events at follow-up*, EUROPEAN HEART JOURNAL (2005), <http://www.ncbi.nlm.nih.gov/pubmed/15618069>.

Medicare population with atherosclerosis, the correct diagnosis of an individual patient's disease etiology is essential for treatment directed towards the underlying disorder. Clinicians who have access to these diagnostic tools can develop a personalized healthcare plan for their patients, including modifications to diet, exercise, and medication.

Clinically-appropriate, physician-ordered testing for cardiovascular risk can also lead to lower costs for taxpayers. These tests typically cost between \$15 - \$45 dollars, much less than the cost of acute and post-acute care for patients who have a cardiac episode. Of note, an April 2015 study in the *Journal of Medical Economics* estimated that biomarker testing among a subgroup of health plan members 35 years old and older significantly reduced cardiac events, yielding a cost savings of \$187 million over 5 years for a patient population of one million members, or \$3.13 per member per month, excluding test costs.⁴ The potential savings to the Medicare program, which has 54 million beneficiaries,⁵ would amount to more than \$10 billion over 5 years.

To make health care for our seniors accessible and affordable, we must identify and foster innovative, value-based approaches to disease prevention and management. To the contrary, implementation of the proposed LCD would preclude Medicare beneficiaries in your jurisdiction from accessing this type of diagnostic testing. **I urge, therefore, that the proposed LCD DL36358 be retracted, and that the MACs engage with clinicians and researchers to better understand their perspectives on these life-saving tests and develop a clinically-appropriate policy.**

Sincerely,



Tom Price, M.D.

CC: Arthur Lurvey, MD, FACP, FACE, Medical Director, Noridian Healthcare Solutions, LLC.

Harry Feliciano, MD, MPH, Medical Director, Palmetto GBA

Earl Berman MD, FACP, Medical Director, CGS Administrators, LLC

³ Ballantyne CM et al., *Lp-PLA2, CRP and risk for incident ischemic stroke in middle aged men and women in the ARIC Study*, ARCHIVES OF INTERNAL MEDICINE (2005), <http://www.ncbi.nlm.nih.gov/pubmed/16314544>.

⁴ M.S. Penn et al., *The Economic Impact of Implementing a Multiple Inflammatory Biomarker-based Approach to Identify, Treat, and Reduce Cardiovascular Risk*, JOURNAL OF MEDICAL ECONOMICS (April 1, 2015), <http://www.ncbi.nlm.nih.gov/pubmed/25763924>.

⁵ *2014 CMS Statistics*, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf.

TOM PRICE, M.D.
6TH DISTRICT, GEORGIA

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COMMITTEE ON THE BUDGET
CHAIRMAN

COMMITTEE ON WAYS AND MEANS

Congress of the United States
House of Representatives

February 8th, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt:

I am writing in response to a December 11, 2015 National Supplier Clearinghouse (NSC) announcement pertaining to Medicare policy on "consignment closets." This policy change is another example of CMS' failure to recognize the reality faced by patients and their physicians and thereby disrupt patient care.

Consignment closet arrangements have long been used by physician offices and hospitals in outpatient settings as a convenient way to ensure that their patients can expeditiously receive needed durable medical equipment, orthotics, prosthetics and supplies (DMEPOS) without the physician or hospital having to enroll as Medicare suppliers. For instance, a patient who seeks treatment from a physician for a foot fracture can receive the appropriate walking boot on the spot from an orthotics specialist working on behalf of an accredited orthotics supplier, without the injured beneficiary needing to travel to find a Medicare-participating supplier and without the physician having to go through the rigorous and expensive process of becoming a Medicare DMEPOS supplier.

According to the new NSC announcement, CMS has recently released clarification of the rules for the use of consignment closets. Although no new CMS policy is actually cited and we are unable to identify any such recent release, the NSC states that in order for a DMEPOS supplier to bill for items furnished through a consignment closet arrangement, "the DMEPOS supplier cannot be present or perform any functions at the medical provider/supplier facility." This significant change bars common arrangements through which orthotics specialists help physicians and hospitals furnish the most appropriate braces and other orthotics to their Medicare patients. If this policy stands, it will impede patient access to medically necessary items.

It is very alarming that this CMS/NSC policy appears to have been issued without any public notice or comment opportunity, despite the significant impact this policy would have on suppliers and providers. It also appears to be effective immediately, which creates immediate access issues for patients and disrupts physician practices.

Given the fact that there has been no appropriate notice to the medical community about potential changes to the consignment closet policy, I insist that CMS instruct the NSC to retract its new guidance. Instead, any changes by CMS to consignment closet policy should always be made through the regular notice and comment rulemaking process.

This new policy change will continue to put patients at risk with each passing day. I look forward to your prompt response with a resolution for this critically important issue.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas Price", enclosed within a large, hand-drawn oval.

Tom Price, M.D.
Member of Congress

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, February 25, 2016 6:23 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Dugan, Meghan; O'Reilly, Megan (CMS/OL); Martino, Maria (CMS/OL)
Subject: Re: Rep. Price (GA) Call with Dr. Patrick Conway

Wonderful, thanks!

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

On Feb 25, 2016, at 6:12 PM, Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov> wrote:

Hello Carla & Meghan – as a follow-up to our conversation, we have scheduled a call on Friday, Feb 26th at 9:15am EST between Rep. Price and Dr. Patrick Conway to discuss our hardship application. To access the call, please dial [redacted] and when prompted Meeting Number: [redacted]. Thanks for all your help on short notice. BTW, I will be out of the office on Friday, so if you have any concerns, please contact Maria or Megan at 202-690-8820.

-Al

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, March 3, 2016 3:40 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Hill Notification: HHS Reaches Goal of Tying 30 Percent of Medicare payments to Quality Ahead of Schedule

Thanks Al,

How does this align with HHS' stated goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016, and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs? Does that goal still exist? How is this different?

Thanks!
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]

Sent: Thursday, March 03, 2016 3:15 PM

To: Bucklen, Kim L. (CMS/CQISCO); Howell, Cherie A. (CMS/OL); Davis, Stephanie M. (CMS/CQISCO); Wattenmaker, Lauren (CMS/CQISCO); Medley, Megan; Bishop, Cameron; Hobbs, Lora; Weinstein, Matt; Gregory Dangelo (Sessions/Budget); Hankey, Mary Blanche (Sessions); Pettitt, Mark; Fike, Cari; Trainor, Sophie; Sessions, Jeff (Emily_Mcbride@sessions.senate.gov); Beard, Hillary; Shelby, Richard (Dayne Cutrell); White, Jerry; Seum, Kristin; Power, Thomas; Bill Nelson (Rachel Pryor); Martinelli, Nick; Brown, Elizabeth; Kim, Edward; Gonzalez, Cesar; Wootton, Alyssa; Skitsko, Catherine; Rose, Ashley; Richard, Joel; Canfield, Ryan; Cho, James; Montes, David; Thomas, Hill; Racalfo, Joe; Ashley, Kevin; Price, Matthew; Brinck, Casey; Manzano, Ian; Kobernat, Dolly (Bill Nelson); Malmgren, Corey (Bill Nelson); Mekhdjavakian, Taleen (Bill Nelson); Cihota, Diane; Orenstein, Spencer; Fisher, Christopher; Nelson, Bill (Alyssa Wang); Doheny, Danielle; Schartner, Anna; Kapavik, Christen; Dresen, Rachel; Callahan, Andrew; Moore, Jessica; Brooks, Wes; Gately, Nathan; Cummings, Timothy; Rubio, Marco (Eduardo Sacasa); Simon, David; Walsh, James; Kumar, Rosalyn; Arkin, Sarah; Farhadian, Sarah; Bess, Garrett; Tyrrell, Andrew; Austin, Keenan; Johnson, Kyle; Hunter, Katie; Bartolomeo, Jordan (Isakson); Halpern, Jonathan; Cannon, Chase; Choudhry, Jennifer; Evans, Katie; David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov); Lattany, Lauren; Eunice, John (Perdue); Butler, Bo; Anderson, Rebecca; Calvo, Michael; Isakson, Johnny (Chance Phiniezy); Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov); Isakson, Johnny (Maureen Rhodes); Hariharan, Arya; Dorney, Thomas; Randall, Easton; Perdue, David (Sarah Schatz); Street, Amanda; Palmer, Ashley; DiBlasio, Carla; Beal, Mary Dee; Layson, Jessica; Riley, Mary Christina; Rossi, Janet; Brooke, Francis; Burkhalter (Paul), Natalie; Conklin, Jennifer (McConnell); Jackson, Megan (Spindel); Katelyn Conner; Cranston, Seana; 'McConnell, Mitch'; Paul, Rand (Bonnie Honaker); Rickett, Shannon; Booth, Taylor; Phelps, Jessica; Marshall, Zack; Allred, SarahLloyd (Wicker); Horton, Cory; Cochran, Thad (Constance Payne); See, Jordan; Swisher, Eliza; Gaddis, Tara; Rush, Anna; Avant, Lanier; (Esther_Clark@burr.senate.gov); (Susan_Hatfield@burr.senate.gov); Abram, Anna (HELP Committee); Franklin, Margaret; Brown, Sandra; McClendon, Shaniqua; Burr, Richard (Andrea_Davis@burr.senate.gov); Burr, Richard (Angela Boothe); Burr, Richard (Colin Rom); Britton, Cammie; Sills, Dennis; Taylor, Annette; Thompson, Kristi; Cooke, Jason; Bell, Preston; Bowlen, Joshua; Meek, Nancy; Enos, Zachary; Jelnicky, Michelle; Thrift, Laura; Blalock, Nora; Sanders, Kyle; Tillis, Thom (Matt Flynn); Tillis, Thom (Ray Starling); Stringer, Meghan; Heimbach, Joel; Palmer,

Ashli; Patterson, Addie; Spencer, Nicholas; Graham, Lindsey (Jessica Phillips-Tyson); Graham, Lindsey (Nick Myers); Binkholder, Natalee; Prianti, Marissa (L. Graham); Brooks, Courtney; Ouimette, Justin; Scott, Tim (Claire Brandewie); Scott, Tim (Will Holloway); Rich, Candace; Alexander, Lamar (Meeks, Brett); Mitchell, Katie; Toomey, Jon; Summar, Karen; Hippe, Jim; Wadkins, Randy; Curtis, Ann Waller; Corker, Bob (Hayly Humphreys); Vaughn, Richard; Cohen, Lauren; DeBerry, Caroline; Eblen, Alex (Corker); Schrodt, Corey; Ingram, Conner; Lapinski, MarySumpter (HELP Committee); Osborn, Sarah (Corker); Meyer, Matt; Tatgenhorst, James (Corker)
<James_Tatgenhorst@corker.senate.gov>

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: HHS Reaches Goal of Tying 30 Percent of Medicare payments to Quality Ahead of Schedule

U.S. House and Senate Notification

Thursday, March 3, 2016

To: Congressional Health Staff

From: Megan O'Reilly

Director, Office of Legislation

Centers for Medicare & Medicaid Services

Re: HHS Reaches Goal of Tying 30 Percent of Medicare payments to Quality Ahead of Schedule

The Department of Health and Human Services (HHS) announced today that an estimated 30 percent of Medicare payments are now tied to alternative payment models that reward the quality of care over quantity of services provided to beneficiaries. Today's announcement means that over 10 million Medicare patients are getting improved quality of care by having more time with their doctors and better coordinated care – nearly a year ahead of schedule.

Alternative payment models are ways for Medicare to pay providers based on the health of the patient and quality of care rather than the number of services provided. Examples include accountable care organizations (ACOs), advanced primary care medical homes, and new models that bundle payments for episodes of care. In January 2015, the Administration announced clear goals and a timeline for shifting Medicare payments from quantity to quality, setting a goal of 30 percent of Medicare payments through alternative payment models by the end of 2016. With the January 2016 announcement of 121 new ACOs as well as greater provider participation in other models, HHS today estimates that it has achieved that goal well ahead of schedule.

Today's estimates were evaluated by the independent Centers for Medicare & Medicaid Services (CMS) Office of the Actuary and found to be sound and reasonable. As of January 2016, CMS estimates that roughly \$117 billion out of a projected \$380 billion Medicare fee-for-service payments are tied to alternative payment models.

A press release about today's announcement will be available at: <http://www.hhs.gov/about/news/index.html>. A fact sheet about the announcement is attached and will also be available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html>. A fact sheet about the models is attached and will also be available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03.html>. The actuarial analysis will be available at: <https://innovation.cms.gov/files/x/ffs-apm-goalmemo.pdf>.

If you have any questions, please contact the CMS Office of Legislation. Thank you.

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Sent: Thursday, March 17, 2016 9:44 AM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Dugan, Meghan; Howell, Cherie A. (CMS/OL)
Subject: RE: Follow-up to call with Chairman Price and Patrick Conway

Will do, thanks Al!

Yep, he'll want to focus most of the conversation on CJR, more specifically the upcoming CJR implementation on April 1st. Chairman Price may briefly bring up the shoulder issue and his concerns about the new Part B drug demo, as well.

Congressman Price really appreciates the opportunity to have an open conversation with Dr. Conway, so we really appreciate you keeping the lines of communication open.

Thanks so much!
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Thursday, March 17, 2016 9:40 AM
To: DiBlasio, Carla
Cc: Dugan, Meghan; Howell, Cherie A. (CMS/OL)
Subject: RE: Follow-up to call with Chairman Price and Patrick Conway

Good Morning Carla & Meghan – please send us some dates/times next week Chairman Price is available and we'll see what works for Patrick. To be clear, the Congressman wants to discuss CJR and the shoulder issue? Thanks.

-Al

From: DiBlasio, Carla [mailto:Carla.Diblasio@mail.house.gov]
Sent: Wednesday, March 16, 2016 3:41 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Dugan, Meghan
Subject: RE: Follow-up to call with Chairman Price and Patrick Conway

Hey Al,

I hope you're doing well. I had the pleasure of speaking with Jen Druckman last week. She instructed me to follow-up with you to setup a call with Patrick Conway and Congressman Price so they may discuss CJR. Is there any availability for a call next week? I've copied our scheduler, Meghan Dugan.

Thanks, as always!
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: DiBlasio, Carla
Sent: Wednesday, March 02, 2016 12:54 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: RE: Follow-up to call with Chairman Price and Patrick Conway

Thanks All!

I apologize I've been stuck in meetings all day. I've attached the letter my boss recently sent to CMS on the shoulder issue. I've also attached the letter my boss sent to CMS on CJR back in September. I realize that CMS responded and CJR was since finalized. However, many of his concerns remain the same.

I was hoping to learn more about Patrick Conway's ideas for reform in the Meaningful Use program for 2016. This was follow-up to the phone with Patrick Conway last week. I believe I emailed you and Jennifer Druckman about it last week.

I'll call you this afternoon in between meetings. Let me know if you prefer a specific time, and I'll do my best to accommodate. My schedule has been in flux today. Thanks so much for your patience.

Best,
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]
Sent: Wednesday, March 02, 2016 10:51 AM
To: DiBlasio, Carla
Subject: RE: Follow-up to call with Chairman Price and Patrick Conway

Hello Carla –

Can you give me a call this afternoon to discuss your orthopedic issues/CJR/shoulder coding issues call request? Thanks.

Al Chadwick
Office of Legislation/Congressional Affairs Group
Centers for Medicare & Medicaid Services
200 Independence Ave, SW
Room 351G
Washington, DC 20201
202-690-5519 (Phone)
202-690-8168 (Fax)
alpheus.chadwick@cms.hhs.gov

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Friday, February 26, 2016 3:32 PM
To: Druckman, Jennifer (CMS/OL)
Cc: Chadwick, Alpheus K. (CMS/OL)
Subject: Follow-up to call with Chairman Price and Patrick Conway

Hey Jennifer,

Thanks so much for arranging the call with Patrick Conway and Congressman Price. I know Dr. Price thought it was a helpful conversation. Dr. Price would like me to follow-up with you in another phone call to discuss options for Congress to create greater flexibility in the program in 2016 that would also be helpful/workable for CMS. Do you have time for a call early next week?

Additionally, Dr. Price would like me to arrange another call for him to discuss orthopedic issues with CMS, including CJR and a shoulder coding issue. I informed Al last night of Dr. Price's intention of bringing it up with Patrick Conway this morning, but Al led me to believe that we would need to setup a separate call for that.. and that would be possible. We greatly appreciate the helpful dialogue!

Thanks again!
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Thursday, March 17, 2016 1:30 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: Rep. Price (GA) Follow-Up Items
Attachments: PTAC_Slides.pdf

Carla –

As a follow-up re the items we discussed this morning:

- A.) The website for the Physician-Focused Payment Model Technical Advisory Committee is here:
<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>

The slides from the first meeting are attached.

The contact person is:

Scott R. Smith
Director, Division of Healthcare Qualities and Outcomes
Office of Health Policy, ASPE
Scott.Smith@hhs.gov

- B.) The Prevention and Public Health Fund – you can reach out to Robin Goracke (robin.goracke@hhs.gov) or Bridgett Taylor (Bridgett.taylor@hhs.gov) in the HHS Office of the Assistant Secretary for Legislation at 202-690-7450.

Please let me know if you have any questions. Thanks.

-AI

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, March 17, 2016 9:08 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Martino, Maria (CMS/OL)
Subject: RE: Rep. Price (GA) Follow-Up Items
Attachments: BPCI Concerns from Signature Medical Group_Letter to Dr. Price.pdf

Thanks so much, Al!

I really appreciate your helpful follow-up. Per our conversation this morning, I've attached a detailed letter addressed to Congressman Price from Signature Medical Group. They represent 55 orthopedic practices from 26 states currently participating in the Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement (BPCI) initiative.

Signature is experiencing a number of problems with the BPCI program. I would really like to get your feedback on each specific concern. That way I may not need to formally elevate this to my boss. Can CMS kindly provide feedback on each of the concerns?

Thanks again, Al!

Best,
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Thursday, March 17, 2016 1:30 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: Rep. Price (GA) Follow-Up Items

Carla –

As a follow-up re the items we discussed this morning:

- A.) The website for the Physician-Focused Payment Model Technical Advisory Committee is here:
<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>

The slides from the first meeting are attached.

The contact person is:

Scott R. Smith
Director, Division of Healthcare Qualities and Outcomes
Office of Health Policy, ASPE
Scott.Smith@hhs.gov

- B.) The Prevention and Public Health Fund – you can reach out to Robin Goracke (robin.goracke@hhs.gov) or Bridgett Taylor (Bridgett.taylor@hhs.gov) in the HHS Office of the Assistant Secretary for Legislation at 202-690-7450.

Please let me know if you have any questions. Thanks.

-AI

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Page 94 redacted for the following reason:

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Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Monday, March 21, 2016 7:21 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Martino, Maria (CMS/OL)
Subject: RE: Rep. Price (GA) Follow-Up Items

Thanks again, Al!

I hope you had a great weekend. I really appreciate all your help.

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Friday, March 18, 2016 9:17 AM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: RE: Rep. Price (GA) Follow-Up Items

Good Morning Carla – we'll take a look at the issues raised by Signature and circle back. Thx.

-Al

From: DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]
Sent: Thursday, March 17, 2016 9:08 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Martino, Maria (CMS/OL)
Subject: RE: Rep. Price (GA) Follow-Up Items

Thanks so much, Al!

I really appreciate your helpful follow-up. Per our conversation this morning, I've attached a detailed letter addressed to Congressman Price from Signature Medical Group. They represent 55 orthopedic practices from 26 states currently participating in the Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement (BPCI) initiative.

Signature is experiencing a number of problems with the BPCI program. I would really like to get your feedback on each specific concern. That way I may not need to formally elevate this to my boss. Can CMS kindly provide feedback on each of the concerns?

Thanks again, Al!

Best,
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]

Sent: Thursday, March 17, 2016 1:30 PM

To: DiBlasio, Carla

Cc: Martino, Maria (CMS/OL)

Subject: Rep. Price (GA) Follow-Up Items

Carla –

As a follow-up re the items we discussed this morning:

- A.) The website for the Physician-Focused Payment Model Technical Advisory Committee is here:
<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>

The slides from the first meeting are attached.

The contact person is:

Scott R. Smith
Director, Division of Healthcare Qualities and Outcomes
Office of Health Policy, ASPE
Scott.Smith@hhs.gov

- B.) The Prevention and Public Health Fund – you can reach out to Robin Goracke (robin.goracke@hhs.gov) or Bridgett Taylor (Bridgett.taylor@hhs.gov) in the HHS Office of the Assistant Secretary for Legislation at 202-690-7450.

Please let me know if you have any questions. Thanks.

-Al

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, April 21, 2016 6:42 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Zebley, Kyle
Subject: MACRA letter
Attachments: Final signed MACRA letter 4-20-2016.pdf

Al,

I hope this email finds you well! Please find attached a signed copy of the letter that Reps. Price, Bucshon, Pascrell and Loeb sack sent CMS this week relating to MACRA implementation.

Many thanks!
Carla

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



Congress of the United States
Washington, DC 20515

April 20th, 2016

Sylvia Mathews Burwell
Secretary
Department of Health and Human Services
Room 120F
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Andrew M. Slavitt
Administrator (Acting)
Centers for Medicare and Medicaid Services
Room 310G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell and Acting Administrator Slavitt:

We write to urge the Department of Health and Human Services (HHS), particularly the Centers for Medicare and Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation to ensure that the Department engages with physician and medical specialty groups in a timely and productive manner to accelerate the development of alternative payment models (APMs).

In crafting the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress put an emphasis on modernizing our health system with a particular focus on methods of payment based on the value of care. MACRA is built on the principle of encouraging provider groups to develop APMs that can ultimately be adopted by CMS and commercial payers. Specifically, MACRA encourages physician and medical specialty groups to submit APM proposals to the Physician-Focused Payment Models Technical Advisory Committee (PTAC). As you know, this process was created by MACRA to capitalize on medical expertise by actively involving stakeholders in the development of APMs and to increase the variety, efficacy, and number of qualified APMs, maximizing the number of physicians and medical specialties that would be able to participate in them.

The physician community strongly supports this provision in MACRA. Currently, many medical specialties are re-examining how their physicians are paid and investing significant time and resources in developing models that will incentivize and facilitate high quality care and improved patient outcomes. We believe that a timely and efficient implementation process at HHS will be critical to realizing the promise of this provision of MACRA.

First, we urge the Administration to review and quickly implement as many physician-focused APMs as possible. CMS has indicated that its current process for reviewing and implementing an APM requires one to two years to complete, and that the resources needed to carry out this process limit the number of APMs that can be implemented. The Secretary should eliminate unnecessary steps and requirements to establish a fast-track process for implementing APMs that are developed by medical societies and hold promise for improving patient care and/or generating savings. With the likely first performance period for payment updates in 2019 fast approaching, timely implementation is essential for all stakeholders involved.

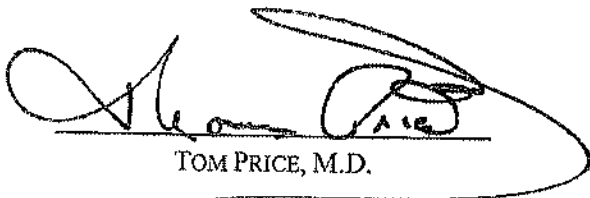
Second, it is our hope that the APM provisions of MACRA will lead to a diverse array of APMs developed by providers, including models for small physician practices, specialists, and rural physicians. Consequently, we urge HHS and CMS to offer assistance to physicians and medical societies in the development of APM proposals by providing feedback and transparency, including access to data.

Third, we urge the agencies to give priority consideration to models recommended by the PTAC. MACRA created this provision in the hopes that it would lead to a proliferation of physician-focused payment models applicable to a wide variety of specialties.

Finally, we urge the agencies to ensure that the PTAC provides helpful feedback at an early stage on whether participation in a proposed APM is an acceptable alternative to participation in the Merit-Based Incentive Payment System. APMs must be meaningful to improve health care delivery and allow for more than nominal risk, and physician and medical specialty groups need to receive clear feedback on the strength of their proposals in order to generate successful APMs.

We share the goal of improving Medicare by empowering providers to work with us to improve patient care. Physician and medical specialty groups are uniquely positioned to help develop effective APMs that take into account the unique needs of patients with different health conditions. We ask the Secretary to move quickly to publish for public comment the criteria the PTAC will use to evaluate proposed APMs and announce a clear process for the submission, review, approval, and implementation of proposed APMs, and to provide as much technical assistance as needed to providers and their medical societies regarding APM development. We ask the Secretary to expeditiously review and implement such APMs developed by physicians and medical societies. We look forward to working with you to implement this important law.

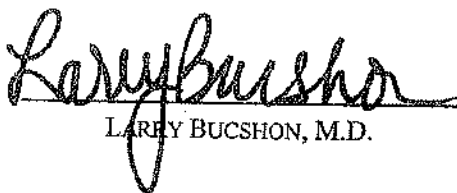
Sincerely,



TOM PRICE, M.D.



BILL PASCRELL, JR.



LARRY BUCSHON, M.D.



DAVID LOEBSACK

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Friday, May 13, 2016 7:39 AM
To: 'Dugan, Meghan'
Cc: DiBlasio, Carla; Twomey, John; Martino, Maria (CMS/OL); O'Reilly, Megan (CMS/OL)
Subject: RE: Follow-up call

Good Morning Meghan –

Because Dr. Conway will be in Baltimore today, we have arranged a conference line for today's 1:30pm call between Dr. Price and Dr. Conway. Please dial _____ to access the call, and when prompted Meeting Number: _____ Thanks.

-Al

From: Martino, Maria (CMS/OL)
Sent: Tuesday, May 10, 2016 10:02 AM
To: 'Dugan, Meghan' <Meghan.Dugan@mail.house.gov>; O'Reilly, Megan (CMS/OL) <Megan.OReilly@cms.hhs.gov>
Cc: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>; Twomey, John <John.Twomey@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: RE: Follow-up call

Hi Meghan—we're confirmed for Friday at 1:30. I assume Dr. Price will still want to call Dr. Conway? His phone is 202.690.6726.

From: Dugan, Meghan [<mailto:Meghan.Dugan@mail.house.gov>]
Sent: Monday, May 9, 2016 6:10 PM
To: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>; O'Reilly, Megan (CMS/OL) <Megan.OReilly@cms.hhs.gov>
Cc: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>; Twomey, John <John.Twomey@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: RE: Follow-up call

1:30 on Friday will be perfect thank you so much!

From: Martino, Maria (CMS/OL) [<mailto:Maria.Martino@cms.hhs.gov>]
Sent: Monday, May 09, 2016 5:04 PM
To: Dugan, Meghan; O'Reilly, Megan (CMS/OL)
Cc: DiBlasio, Carla; Twomey, John; Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Follow-up call

How about any of these:

Thu, May 12: 1:30 or 2:00
Fri, May 13: 8:30, 10:00, 1:30, 3:30

From: Dugan, Meghan [<mailto:Meghan.Dugan@mail.house.gov>]

Sent: Monday, May 9, 2016 4:46 PM

To: OReilly, Megan (CMS/OL) <Megan.OReilly@cms.hhs.gov>

Cc: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>; Twomey, John <John.Twomey@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>; Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>

Subject: RE: Follow-up call

Megan,

Sorry to change things up last minute but we had a conflict arise tomorrow during the time we had set aside for the call. Is there any way we could move the call to later in the week, like on Thursday or Friday?

Thanks!

From: OReilly, Megan (CMS/OL) [<mailto:Megan.OReilly@cms.hhs.gov>]

Sent: Wednesday, May 04, 2016 12:15 PM

To: Dugan, Meghan

Cc: DiBlasio, Carla; Twomey, John; Chadwick, Alpheus K. (CMS/OL); Martino, Maria (CMS/OL)

Subject: RE: Follow-up call

This is the best number to use and we will connect Dr. Price to Patrick. 202.690.6726

From: Dugan, Meghan [<mailto:Meghan.Dugan@mail.house.gov>]

Sent: Wednesday, May 4, 2016 8:31 AM

To: OReilly, Megan (CMS/OL) <Megan.OReilly@cms.hhs.gov>

Cc: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>; Twomey, John <John.Twomey@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>; Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>

Subject: Re: Follow-up call

Megan,

1:00 will work perfectly for our schedule. What is the best number for Dr. Price to use?

Thank you,
Meghan

On May 3, 2016, at 7:08 PM, OReilly, Megan (CMS/OL) <Megan.OReilly@cms.hhs.gov> wrote:

Could 9:30 or 1 pm work?

From: OReilly, Megan (CMS/OL)

Sent: Tuesday, May 03, 2016 07:42 PM

To: 'Carla.Diblasio@mail.house.gov' <Carla.Diblasio@mail.house.gov>; OReilly, Megan (CMS/OL)

Cc: 'Meghan.Dugan@mail.house.gov' <Meghan.Dugan@mail.house.gov>;

'John.Twomey@mail.house.gov' <John.Twomey@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL);
Martino, Maria (CMS/OL)

Subject: Re: Follow-up call

Thanks Carla- let us get some times for you and will follow-up tomorrow.

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Tuesday, May 03, 2016 07:09 PM
To: O'Reilly, Megan (CMS/OL)
Cc: Dugan, Meghan <Meghan.Dugan@mail.house.gov>; Twomey, John <John.Twomey@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL)
Subject: Follow-up call

Hey Megan,

Thanks again for your follow-up on the MACRA rule. Congressman Price would like to setup a MACRA follow-up call with Dr. Conway next week once he's back in DC. Do you have any availability on Tuesday afternoon next week for a quick call? I've copied our scheduler here.

Many thanks!
Carla

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

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Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Friday, May 13, 2016 7:46 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Martino, Maria (CMS/OL)
Subject: RE: Rep. Price (GA) Follow-Up Items

Thanks again, Al.

Have a wonderful weekend!

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Friday, May 13, 2016 12:10 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: RE: Rep. Price (GA) Follow-Up Items

Hello Carla –

Please see our responses below to the remaining questions and let me know if you have any questions. Thanks.

-Al

- 1) Dr. Price is very interested to see the BPCI data that CMS is relying on, in addition to the report evaluating BPCI.

A: Attached please find the first evaluation report for BPCI Models 2, 3, and 4, issued in February 2015. We do not have other publicly available BPCI data at this time. The second evaluation is under development and we will send that to you, once it is available.

- 2) Dr. Price asked the following question of Dr. Conway:
If a hospital sees a patient mix of very complicated surgeries, they are going to have much higher costs regardless of how well the patient is treated. CJR stratifies risk based only on MS-DRG code and whether a patient has a hip fracture. Unless a more robust risk stratification method is implemented to accommodate higher risk/more complex procedures under CJR, “cherry-picking” could occur.
Why is there not a risk-adjustment formula that takes into account a variety of other risk factors?

A: Based on comments received in response to the proposed CJR rule, CMS established a risk stratification methodology to set different target prices for patients with hip fractures. Target prices in CJR are risk stratified by both MS-DRG (indicating the presence or absence of major complications or comorbidities) and fracture status. Four target prices are calculated for each participant hospital (MS-DRG 469 without fracture, MS-DRG 469 with fracture, MS-DRG 470 without fracture, and MS-DRG 470 with fracture). These target prices are based on historical episode prices for cases with the corresponding MS-DRG and fracture status. This means that prices for fracture cases are set based on historical spending for these same types of patients, i.e., those who present with a hip fracture. We believe this risk stratification policy addresses risk factors related to CJR patients.

CMS also protects hospitals from very high cost episodes by capping those episodes at a threshold of two standard deviations above the mean episode payment. This means that at the end of a performance year when

actual spending is compared against the target episode price, the actual spending for high-cost episodes are capped at two standard deviations above the mean episode payment. Moreover, stop-loss limits are in place that limit the amount of financial responsibility for hospitals.

- 3) Dr. Price asked Dr. Conway how many physician groups participating in BPCI are practicing within CJR MSAs?

A: Of the 143 physician group practices (PGPs) participating in Models 2 or 3 of BPCI for lower extremity joint replacements, 40 of them are located in CJR MSAs.

- 4) Dr. Price asked the following related to the actual hip/knee devices:

If the choice of a hip or knee device were made solely on the basis of patients' relative health, lifestyle and life expectancy, patients would be provided a device that appropriately demand matched to their unique needs with cost not being a leading driver of this decision, so as to ensure the best possible outcomes and longevity. What are CMS and CMMI doing to protect beneficiaries against excessive standardization of hip and knee device offerings available in hospitals participating in bundled payment programs? What specific protections do you intend to use in CJR to ensure that Medicare patients have access to the most appropriate hip and knee for their lifestyles and overall medical condition?

A: The CJR model is built around an inpatient admission so payments for hip and knee implants and medical devices will continue as usual under the applicable Medicare payment systems. For inpatient admissions paid under IPPS, in particular, implants and medical devices not categorized as eligible for a new technology add-on payment would be included in the MS-DRG payment and would not be paid separately. Since the cost of the device is already bundled into the payment for the hospital admission, the CJR model does not create a separate incentive for hospitals to use a standard or less expensive hip and knee device.

We do not believe that there are any new incentives for hospitals participating in the CJR model to offer devices not appropriate for beneficiaries as the medical device remains packaged in the IPPS payment bundle. However, we will reduce beneficiary risk, if any, by ongoing monitoring of hospitals under the model, and by promoting beneficiary and provider education about the model.

- 5) Dr. Price also mentioned that CMS has acknowledged that it is currently miscoding knee revisions as primary arthroplasty. This error will severely and artificially inflate hospital reported expenditures under the CJR, thereby penalizing CJR participants. We understand that CMS plans to wait until 2017 to correct this error. Thus, Dr. Price asked: *Will CMS correct this error before or shortly after April 1, or otherwise ensure that CJR participants are not unfairly penalized?*

A: As discussed in the FY 2017 IPPS Proposed Rule (81 FR 24993-24996), CMS proposes to add 58 new code combinations that capture knee joint revisions to the Version 34 MS DRG structure for MS-DRGs 466, 467, and 468 effective October 1, 2016. CMS is inviting public comment on this proposal, with comments due by June 17, 2016. Since in the CJR model (as in BPCI) we set prices at the MS-DRG level, we do not anticipate removing such cases from any 2016 data used to determine actual 2016 spending or future year target prices. However, both future year target prices and future actual spending will reflect any finalized modifications to MS-DRG policies for knee revisions.

From: DiBlasio, Carla [mailto:Carla.Diblasio@mail.house.gov]

Sent: Tuesday, May 10, 2016 1:57 PM

To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>

Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>

Subject: RE: Rep. Price (GA) Follow-Up Items

Thanks so much, All!

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Tuesday, May 10, 2016 10:42 AM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: FW: Rep. Price (GA) Follow-Up Items

Hello Carla - attached is the BPCI Evaluation Report. I wanted to send this along as well as let you know that folks here are working on your other questions below. I will send those answers as we receive them.

-Al

From: DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]
Sent: Thursday, May 5, 2016 10:50 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: RE: Rep. Price (GA) Follow-Up Items

Thanks so much, All!

Congressman Price and I greatly appreciate you getting back to me. Additionally, Dr. Price had a couple pending follow-up items from his conversation with Dr. Conway about CJR:

- 1) Dr. Price is very interested to see the BPCI data that CMS is relying on, in addition to the report evaluating BPCI. **Dr. Conway said his staff would be able to get us the BPCI data and the report.**
- 2) Dr. Price asked the following question of Dr. Conway:
If a hospital sees a patient mix of very complicated surgeries, they are going to have much higher costs regardless of how well the patient is treated. CJR stratifies risk based only on MS-DRG code and whether a patient has a hip fracture. Unless a more robust risk stratification method is implemented to accommodate higher risk/more complex procedures under CJR, "cherry-picking" could occur.
Why is there not a risk-adjustment formula that takes into account a variety of other risk factors?
→ Dr. Conway said he would have his staff get back to us with the additional risk factors within the risk-adjustment. More specifically, he said he would be able to get us the risk adjustment percentages.
- 3) Dr. Price asked Dr. Conway how many physician groups participating in BPCI are practicing within CJR MSAs? **Dr. Conway said he would try to get us that answer.**
- 4) Dr. Price asked the following related to the actual hip/knee devices:

If the choice of a hip or knee device were made solely on the basis of patients' relative health, lifestyle and life expectancy, patients would be provided a device that appropriately demand matched to their unique needs with cost not being a leading driver of this decision, so as to ensure the best possible outcomes and longevity. What are CMS and CMMI doing to protect beneficiaries against excessive standardization of hip and knee device offerings available in hospitals participating in bundled payment programs? What specific protections do you intend to use in CJR to ensure that Medicare patients have access to the most appropriate hip and knee for their lifestyles and overall medical condition?

→ Dr. Price would greatly appreciate clarification on this response. Dr. Conway mentioned that he would get back to us on this point. He mentioned something about a device modifier, so it would be wonderful if you could clarify this for us.

- 5) Dr. Price also mentioned that CMS has acknowledged that it is currently miscoding knee revisions as primary arthroplasty. This error will severely and artificially inflate hospital reported expenditures under the CJR, thereby penalizing CJR participants. We understand that CMS plans to wait until 2017 to correct this error. Thus, Dr. Price asked: *Will CMS correct this error before or shortly after April 1, or otherwise ensure that CJR participants are not unfairly penalized?*

→ Dr. Conway said he needed to check with Sean Cavanaugh on this point, but he could get back to us.

Many thanks!!

Carla

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]

Sent: Thursday, May 05, 2016 4:53 PM

To: DiBlasio, Carla

Cc: Martino, Maria (CMS/OL)

Subject: RE: Rep. Price (GA) Follow-Up Items

Hello Carla – sorry for the delay. Below are our responses to the questions raised by Signature in their letter to Congressman Price.

Issue #1 – BPCI End Date

A1. Signature expressed concerns regarding the staggered termination of BPCI entities (end of 2016 and 2018, respectively) and how that may impact beneficiaries previously seen at hospitals now participating in the Comprehensive Care for Joint Replacement (CJR) model. CMS recently announced that BPCI entities will be offered an Amendment to their Awardee Agreements that extends their participation in BPCI. All Awardees that choose to sign this Amendment will extend their period of performance for all clinical episodes until September 30, 2018.

Issue #2 – The National Trend Factor

A2. Signature also expressed concerns over the calculation and application of the National Trend Factor. BPCI spans multiple Medicare fee-for-service payment systems, and operating a payment model within existing CMS

systems creates operational and methodological complexities. We updated our methodology in the Fall of 2014 to limit the quarterly fluctuations in the trend factor. We are continuing to work to update and refine our methodology to increase price stability without increasing the complexity of an already complex initiative.

Issue #3 – Lack of Risk-Adjusted Pricing

A3. Signature notes the increased complexity of trauma and non-elective hip fracture and joint replacement episodes of care and the associated increase in risk and cost for these cases. They believe it is equitable to provide and apply the same risk-adjustment methodology in BPCI that is in CJR. We understand this concern and are considering the impact this request has across BPCI Awardees.

Issue #4 – Attribution Methodology

A4. Signature raises the concern that the methodology used by CMS for patient attribution, or physician reassignment, is flawed and could compromise the success of BPCI. They specifically cite the use of NPI assignment and anchor event determination as concerns with the methodology. CMS identified the Physician Reassignment issue in July 2015 as part of a broader issue regarding the accuracy of information in the Provider Enrollment, Chain, and Ownership System (PECOS) for Physician Group Practices (PGPs) in BPCI. We have been diligently working to resolve this issue, and recently announced plans to address it. CMS plans to address this issue by:

- Requesting all directly impacted Awardees to submit a detailed report of inaccuracies in their current PGP Reassignment List
- Mandating a comprehensive review of these inaccuracies by the Medicare Administrative Contractors (MACs) to resolve any outstanding issues
- Rerunning the report that creates the PGP Reassignment list with the newly resolved data compiled by the MACs
- Deferring collection of any negative Net Payment Reconciliation Amounts (NPRA) at the Episode Initiator level until October 2016 when reconciliation calculations will be completed with the new Physician Group Practice Reassignment Lists

The anchor event determination concerns raised by Signature pertain to how BPCI determines episode attribution. BPCI's episode attribution methodology depends on accurate claims data, as the attending provider or the operating physician listed on the claims form is what CMS uses to trigger BPCI episodes for PGPs. CMS understands the current methodology has posed some issues for some Awardees. CMS is carefully examining these issues and looking at the possibility of alternate approaches.

Please let me know if you have any questions. We will continue to keep you updated on changes to BPCI. Please note that the Innovation Center can make themselves available to talk to Signature if they have any concerns.

-AI

From: DiBlasio, Carla [<mailto:Carla.Diblasio@mail.house.gov>]
Sent: Thursday, March 17, 2016 9:08 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: RE: Rep. Price (GA) Follow-Up Items

Thanks so much, AI!

I really appreciate your helpful follow-up. Per our conversation this morning, I've attached a detailed letter addressed to Congressman Price from Signature Medical Group. They represent 55 orthopedic practices from 26 states currently participating in the Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement (BPCI) initiative.

Signature is experiencing a number of problems with the BPCI program. I would really like to get your feedback on each specific concern. That way I may not need to formally elevate this to my boss. Can CMS kindly provide feedback on each of the concerns?

Thanks again, AI!

Best,
Carla

Carla DiBlasio, Esq.
Policy Advisor
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]
Sent: Thursday, March 17, 2016 1:30 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: Rep. Price (GA) Follow-Up Items

Carla –

As a follow-up re the items we discussed this morning:

- A.) The website for the Physician-Focused Payment Model Technical Advisory Committee is here:
<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>

The slides from the first meeting are attached.

The contact person is:

Scott R. Smith
Director, Division of Healthcare Qualities and Outcomes
Office of Health Policy, ASPE
Scott.Smith@hhs.gov

- B.) The Prevention and Public Health Fund – you can reach out to Robin Goracke (robin.goracke@hhs.gov) or Bridgett Taylor (Bridgett.taylor@hhs.gov) in the HHS Office of the Assistant Secretary for Legislation at 202-690-7450.

Please let me know if you have any questions. Thanks.

-AI

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Tuesday, May 24, 2016 3:38 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Martino, Maria (CMS/OL)
Subject: Re: Bundled Payments for Care Improvement Hip Replacement with Fracture Pricing Stratification

Many thanks for the update!!

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

On May 24, 2016, at 3:34 PM, Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov> wrote:

Hello Carla –

We wanted to update you that CMS plans to modify the Bundled Payments for Care Improvement (BPCI) initiative's pricing methodology for BPCI Models 2, 3, and 4 for Major Joint Replacement of the Lower Extremity Clinical Episodes. This decision was made in response to BPCI Awardee feedback requesting that BPCI adopt a risk stratification approach similar to the Comprehensive Care for Joint Replacement pricing stratification methodology. The modified methodology will incorporate four sub-MS-DRGs that differentiate episodes that include hip fracture, as follows:

- MS-DRG 469 without hip fracture
- MS-DRG 469 with hip fracture
- MS-DRG 470 without hip fracture
- MS-DRG 470 with hip fracture

CMS has informed BPCI Awardees of this change, and is working now to create an amendment to the agreement to implement the modification to the pricing methodology. Once the amendment is approved, Awardees that currently have a Major Joint Replacement of the Lower Extremity clinical episode in BPCI will have the option to sign the amended agreement. Under this amendment, CMS will calculate new baseline and target prices for the Major Joint Replacement of the Lower Extremity Clinical Episode that adjust for whether a beneficiary has a hip fracture.

The BPCI initiative (as authorized under section 1115A of the Social Security Act as added by Section 3021 of the Affordable Care Act) is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and

more coordinated care at a lower cost to Medicare. For more information on the BPCI initiative, please visit: <https://innovation.cms.gov/initiatives/bundled-payments/>.

Please let us know if you have any questions.

-AI

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, May 26, 2016 8:35 AM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Zebley, Kyle; Beck, Gary; Martino, Maria (CMS/OL); Howell, Cherie A. (CMS/OL)
Subject: Re: Letter to CMS on Home Health Prior Authorization

Thanks, All!

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

On May 26, 2016, at 7:57 AM, Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov> wrote:

Good Morning Carla – I will get this letter to the appropriate folks here. Thx.

-Al

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Wednesday, May 25, 2016 8:52 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Zebley, Kyle <Kyle.Zebley@mail.house.gov>; Beck, Gary <Gary.Beck@mail.house.gov>
Subject: Letter to CMS on Home Health Prior Authorization

Good evening, Al

Please find attached a letter to CMS signed by 116 Members of Congress urging CMS to rescind the proposed mandatory prior authorization for home health as a demonstration in five states. We encourage CMS to refrain from moving forward with the proposed demonstration project in order to avoid delays or a disruption in patient care and prevent restrictions on patient access to home health services.

We appreciate your attention to this important matter. Please let me know if you have any questions.

Many thanks,
Carla

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501
<image001.png> <image002.png> <image003.png> <image004.png> <image005.png>

Congress of the United States
Washington, DC 20515

May 25, 2016

Sylvia Mathews Burwell
Secretary
Department of Health and Human Services
Room 120F
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Andrew M. Slavitt
Administrator (Acting)
Centers for Medicare and Medicaid Services
Room 310G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell and Acting Administrator Slavitt:

Home health is a critical service for seniors and people with disabilities that allows them to stay in their home and remain active in the community. The Centers for Medicare and Medicaid Services (CMS) recently issued in its Paperwork Reduction Act Federal Register Notice (PRA Notice) a potential mandatory prior authorization for home health as a demonstration in five states.¹ The Medicare home health benefit allows beneficiaries to receive medically necessary services at home, in the least costly setting, and can support improved care transitions that help to prevent expensive hospital readmissions. Prior authorization has never been applied to post-acute care within fee-for-service Medicare. We encourage you to refrain from moving forward with the proposed demonstration project in order to avoid delays or a disruption in patient care and prevent restrictions on patient access to home health services.

We are concerned that a demonstration project centered on prior approval or “prior authorization” of home healthcare would interfere with the patient-doctor relationship and is in conflict with the policy goal of moving toward patient-centered care. Stated simply, prior authorization of home healthcare imposes a requirement that prevents a patient from receiving home health services after the physician orders home healthcare unless and until an intermediary has reviewed and approved the order.

Under the proposal, a home health agency would be penalized if it attempted to proceed and care for a patient without delay. Under the proposed demonstration, a home health agency that provides care without prior authorization would be penalized with a 25 percent payment reduction, even if the claim were approved as appropriate and payable.²

We are most concerned with the potential impact of a prior authorization demonstration on access to

¹ The proposed demonstration is described in the Paperwork Reduction Act notice in the Federal Register from February 5, 2016. The five states captured by the demonstration include Florida, Texas, Illinois, Michigan and Massachusetts.

² *Supporting Statement Part A – Medicare Prior Authorization of Home Health Services Demonstration*,” CMS-10599 (Feb. 5, 2016), retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS-10599.zip>

care. Requiring prior approval for every home health patient across five states for critically important services that keep people in their homes rather than institutions, often when they are at their most medically vulnerable, will effectively delay and deny home health coverage for countless Medicare beneficiaries. Under this demonstration project, CMS would have to review more than 900,000 claims each year before each patient could receive care. Today, approximately 3.5 million of Medicare's most vulnerable beneficiaries depend on home healthcare services. These patients are often elderly, low income patients with serious illnesses, who are more likely to be disabled, a minority, or female than all other Medicare populations combined.³ An unwarranted disruption and delay in patient care will put the oldest and frailest Medicare beneficiaries at greatest risk.

This demonstration project could limit access to home health services, while generating longer and costlier hospital stays and potentially increasing readmission rates. Many patients find themselves in the most clinically fragile condition during the week following a hospital discharge. It is vitally important that we continue to meet the care needs of Medicare patients during this critical transition time post-hospital discharge.⁴

We are also concerned about what a prior authorization proposal will mean to the taxpayer. CMS estimates that administrating this **demonstration project** would cost taxpayers more than a quarter of a billion dollars.⁵ CMS aims to **reduce fraud and improper payments** within home health agency claims; however, it is unclear to what extent this proposal would actually prevent fraud and the submission of faulty paperwork or claims. Rather than a more focused approach targeting bad actors, this proposal will put a tremendous administrative burden on agencies with absolutely no track record of fraud. Physicians and home health agencies are already required to provide significant documentation for each patient in order to demonstrate a clinical need for home health services. A prior authorization demonstration as proposed would add an increased administrative burden on both physicians and home health agencies, while likely adding little value for identifying and preventing fraud. Further, prior authorization would be a duplicative process as CMS already reviews claims on a pre-payment basis.

Finally, we are concerned about the authority stated by CMS in pursuing prior authorization for home health services. The authority cited in the rule for implementing the program gives the Secretary authority "to develop or demonstrate improved methods for the *investigation and prosecution of fraud* in the provision of care or services under the health programs established by this chapter (emphasis added)."⁶ The proposal to screen every home health service through a prior authorization process for the five identified states, however, tests a method of screening and utilization management, not a

³ Avalere Health, *Medicare Beneficiary Analysis: Key Differentiating Characteristics of Medicare Home Health Beneficiaries*. March 2014 <http://homehealth4america.org/media-center/attach/207-1.pdf>

⁴ Medicare certified home health agencies are required in the conditions of participation to conduct the initial assessment visit "either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date." A prior authorization process could delay care for as long as 10 to 20 days, directly counter to CMS's regulation. Additionally, CMS created a home health performance measure for timely initiation of care that measures the "percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date whichever is later." This National Quality Forum (NQF) endorsed measure has also been included on the Home Health Compare website. Thus, a prior authorization process for home health care would be inconsistent with CMS's measure of quality in home health care.

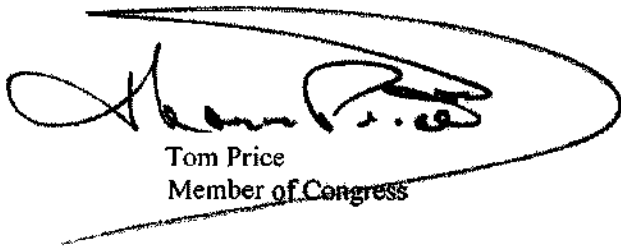
⁵ CMS estimates that the costs associated with performing prior authorization for home health services would be approximately \$223 million in Phase I and an additional \$71.4 million in Phase II over the 3-year demonstration period for just five states. Future expansion of this rule to all 50 states would cause the costs to escalate dramatically.

⁶ 42 U.S.C. Section 1395b-1(a)(1)(J)

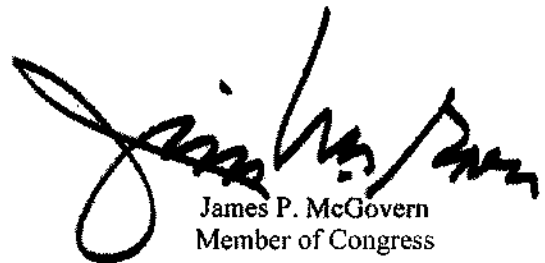
method for investigation or prosecution of fraud. Apart from the question of authority, the PRA Notice is insufficient from an administrative perspective to promulgate such a wide-reaching program. A full notice and comment rulemaking process, allowing stakeholders to comment with specificity on the details of a proposed demonstration project, would be required.

This demonstration project imposes costs on patients, providers and taxpayers. Delaying patient care while waiting for CMS to approve home health services may put patient health in jeopardy and cause patients to stay in the hospital longer than necessary. We ask you to withdraw the proposed demonstration for prior authorization of home health services in order to avoid health risks to patients, delays or disruptions in patient care and unnecessary restrictions on patient access to home health services.

Sincerely,



Tom Price
Member of Congress



James P. McGovern
Member of Congress

C.W. Boustany Jr.
Charles W. Boustany, Jr. M.D.

Niki Tsongas
Niki Tsongas

Corrine Brown
Corrine Brown

Sheila Jackson Lee
Sheila Jackson Lee

John Fleming, M.D.
John Fleming, M.D.

Collin C. Peterson
Collin C. Peterson

Bill Shuster
Bill Shuster

Darrell Issa
Darrell Issa

Sam Johnson
Sam Johnson

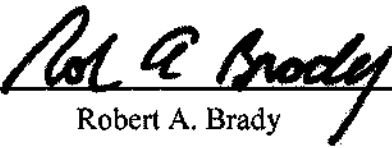
Lamar Smith
Lamar Smith


Ted Poe
Ted Poe

Mick Mulvaney
Mick Mulvaney

Mike Conaway
Mike Conaway

Tom Graves
Tom Graves


Robert A. Brady


Jeff Duncan


Brae Ashford


Lou Barletta


Glenn Thompson


Bruce Westerman

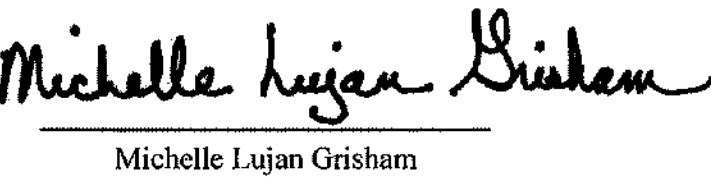

Michael T. McCaul


Ann Kirkpatrick


Garret Graves


Gary Palmer


Patrick E. Murphy


Michelle Lujan Grisham


Scott Tipton


Robert B. Aderholt



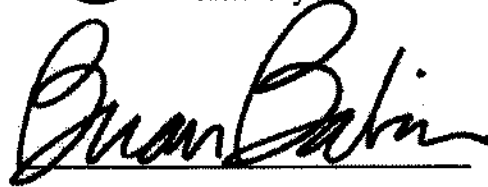
Cedric Richmond



Joe Kennedy III



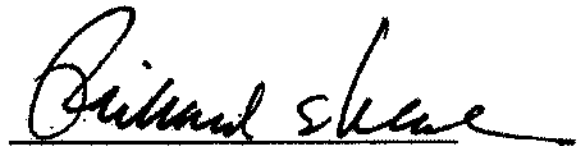
William Keating



Brian Babin



John Ratcliffe



Richard E. Neal



David 'Phil' Roe, M.D.



Tom Marino



David McKinley



Ralph Abraham, M.D.



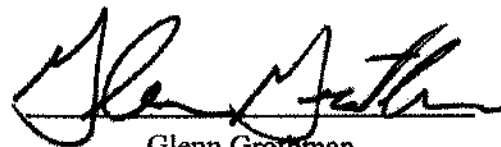
Richard Hudson



Patrick Meehan



Mike Pompeo



Glenn Grothman

Rick W. Allen

Rick Allen

Larry Bucshon

Larry Bucshon, M.D.

Kevin Cramer

Kevin Cramer

H. Morgan Griffith

H. Morgan Griffith

Jason Smith

Jason Smith

Steve Womack

Steve Womack

Sam Farr

Sam Farr

Diane Black

Diane Black

Terri A. Sewell

Terri A. Sewell

Scott Perry

Scott Perry

French Hill

French Hill

Mo Brooks

Mo Brooks

Randy Neugebauer

Randy Neugebauer

Mike Kelly

Mike Kelly

Lynn Jenkins
Lynn Jenkins, C.P.A.

Andy Harris
Andy Harris, M.D.

Rick Crawford
Rick Crawford

Katherine M. Clark
Katherine Clark

Richard Nugent
Richard Nugent

David Jolly
David Jolly

Rodney Davis
Rodney Davis

Vern Buchanan
Vern Buchanan

Pete Olson
Pete Olson

Lynn Westmoreland
Lynn Westmoreland

Mac Thornberry
Mac Thornberry

Steve King
Steve King

Charles Dent
Charles Dent

Jeb Hensarling
Jeb Hensarling

Pete Sessions

Pete Sessions

Vicky Hartzler

Vicky Hartzler

Louie Gohmert

Louie Gohmert

Betty McCollum

Betty McCollum

Marsha Blackburn

Marsha Blackburn

Kenny Marchant

Kenny Marchant

Walter B. Jones

Walter Jones

Yvette D. Clarke

Yvette D. Clarke

Alcee L. Hastings

Alcee L. Hastings

Stephen F. Lynch

Stephen F. Lynch

Steve Chabot

Steve Chabot

John Culberson

John Culberson

Christopher Smith

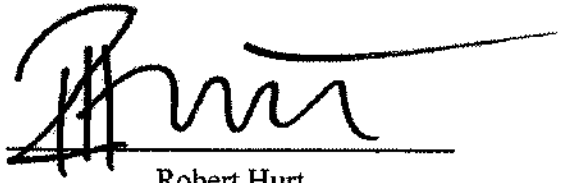
Christopher Smith

Doug Lamborn

Doug Lamborn



Ryan Zinke



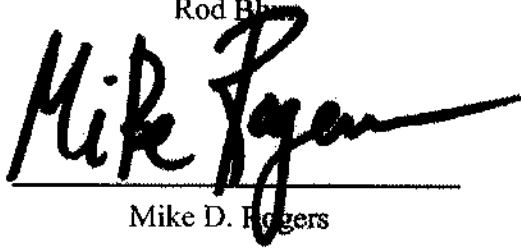
Robert Hurt



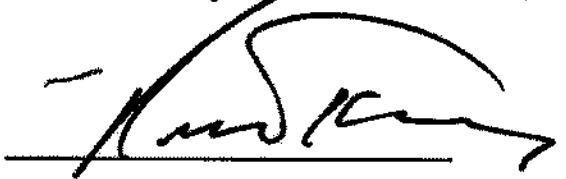
Rod Blum



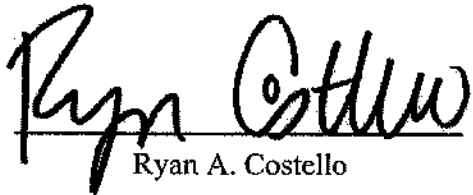
Robert Dold



Mike D. Rogers



Peter King



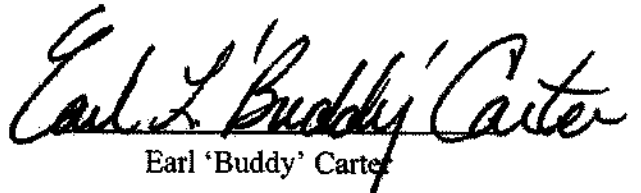
Ryan A. Costello



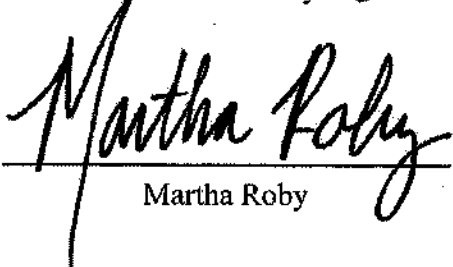
Mike Bishop



Crescent Hardy



Earl 'Buddy' Carter



Martha Roby




Bill Huizenga

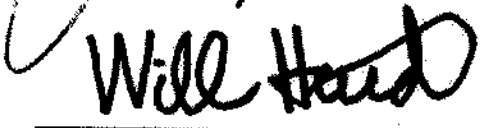


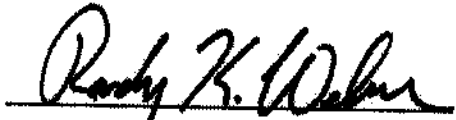
Brad R. Wenstrup, D.P.M.




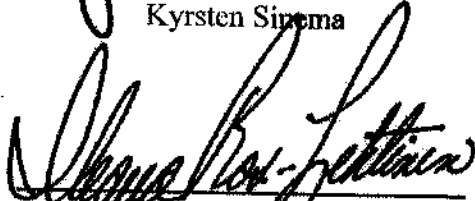
Seth Moulton

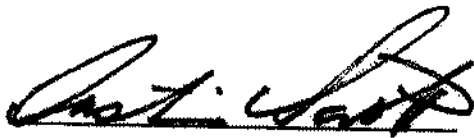

Joe Heck, D.O.



Will Hurd


Randy Weber


Kyrsten Sinema

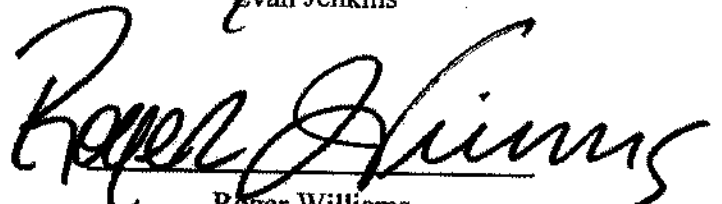

Ileana Ros-Lehtinen



Austin Scott

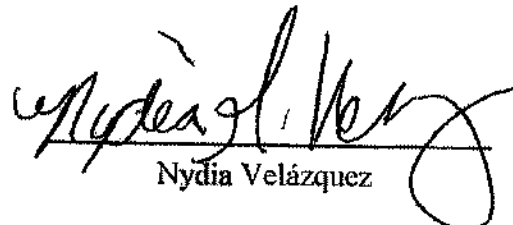

Brian Higgins

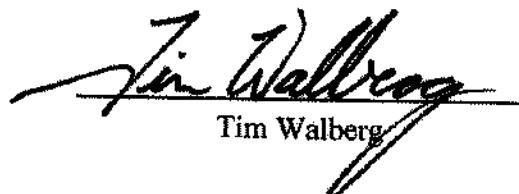

Ann McLane Kuster

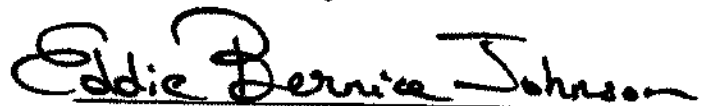

Evan Jenkins


Roger Williams


Ed Whitfield

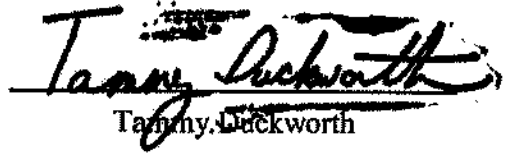

Nydia Velázquez


Tim Walberg


Eddie Bernice Johnson

A stylized, handwritten signature in black ink, appearing to be 'B. Byrne', written over a horizontal line.

Bradley Byrne

A handwritten signature in black ink, appearing to be 'Tammy Duckworth', written over a horizontal line.

Tammy Duckworth

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Friday, June 17, 2016 8:58 PM
To: Howell, Cherie A. (CMS/OL)
Cc: Martino, Maria (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Hello, I just tried to call to make sure you saw CMS Clinical Lab Final Rule Hill Note

Many thanks!! Have a wonderful weekend!

From: Howell, Cherie A. (CMS/OL) [mailto:Cherie.Howell@cms.hhs.gov]
Sent: Friday, June 17, 2016 4:51 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Hello, I just tried to call to make sure you saw CMS Clinical Lab Final Rule Hill Note

Al asked that you get a heads up because of your previous interest. After you have had a chance to read the hill note, if you have questions, feel free to call Al on Monday.

From: DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]
Sent: Friday, June 17, 2016 4:48 PM
To: Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>
Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>; Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: Re: Hello, I just tried to call to make sure you saw CMS Clinical Lab Final Rule Hill Note

Thanks so much for the call.

I apologize I am stuck in a meeting. Happy to call you back if there's anything you'd like to discuss or highlight.

Really appreciate your outreach!

Best,
Carla

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

On Jun 17, 2016, at 4:42 PM, Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov> wrote:

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, July 7, 2016 8:10 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Hill Notification: CMS Proposes Hospital Outpatient Prospective Payment Changes to Better Support Physicians and Improve Patient Care

Al,

Sorry I missed your call yesterday. Thanks so much for taking the time to call. That means a lot to us. We were very pleased to see the 90-day reporting announcement.

Thanks!

Carla

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Wednesday, July 06, 2016 4:22 PM
To: Bucklen, Kim L. (CMS/CQISCO); Howell, Cherie A. (CMS/OL); Davis, Stephanie M. (CMS/CQISCO); Wattenmaker, Lauren (CMS/CQISCO); Medley, Megan; Hobbs, Lora; Weinstein, Matt; Gregory Dangelo (Sessions/Budget); Hankey, Mary Blanche (Sessions); Pettitt, Mark; Fike, Cari; Trainor, Sophie; Wilson, Haley; Sessions, Jeff (Emily_Mcbride@sessions.senate.gov); Beard, Hillary; Shelby, Richard (Dayne Cutrell); White, Jerry; Seum, Kristin; Power, Thomas; Bill Nelson (Rachel Pryor); Martinelli, Nick; Brown, Elizabeth; Kim, Edward; Gonzalez, Cesar; Wootton, Alyssa; Harden, Catherine; Rose, Ashley; Brown, Rebecca; Richard, Joel; Canfield, Ryan; Cho, James; Thomas, Hill; Racalto, Joe; Ashley, Kevin; Ferrell, La Rissa; Price, Matthew; Brinck, Casey; Manzano, Ian; Kobernat, Dolly (Bill Nelson); Malmgren, Corey (Bill Nelson); Mekhdjavakian, Taleen (Bill Nelson); Waldrip, Brian; Cihota, Diane; Orenstein, Spencer; Fisher, Christopher; Nelson, Bill (Alyssa Wang); Doheny, Danielle; Schartner, Anna; Kapavik, Christen; Dresen, Rachel; Callahan, Andrew; Moore, Jessica; Brooks, Wes; Gately, Nathan; Cummings, Timothy; Rubio, Marco (Eduardo Sacasa); Walsh, James; Kumar, Rosalyn; Arkin, Sarah; Farhadian, Sarah; Bess, Garrett; Tyrrell, Andrew; Austin, Keenan; Johnson, Kyle; Bishop, Cameron; Hunter, Katie; Bartolomeo, Jordan (Isakson); Halpern, Jonathan; Cannon, Chase; Choudhry, Jennifer; Evans, Katie; David Perdue (PJ Waldrop) (pj_waldrop@perdue.senate.gov); Lattany, Lauren; Eunice, John (Perdue); Butler, Bo; Murphy, Jason (Rep. Tom Graves); Calvo, Michael; Isakson, Johnny (Jay_Sulzmann@isakson.senate.gov); Isakson, Johnny (Maureen Rhodes); Hariharan, Arya; Dorney, Thomas; Carr, Colin; Randall, Easton; Street, Amanda; Palmer, Ashley; DiBlasio, Carla; Beal, Mary Dee; Porter, Amber; Rossi, Janet; Brooke, Francis; Burkhalter (Paul), Natalie; Jackson, Megan (Spindel); Lewis, Katie (Paul); Cranston, Seana; 'McConnell, Mitch'; McConnell, Mitch (Natalie McIntyre); Paul, Rand (Bonnie Honaker); Rickett, Shannon; Leonard, Cassie; Phelps, Jessica; Marshall, Zack; Allred, SarahLloyd (Wicker); Horton, Cory; Cochran, Thad (Elizabeth Joseph); Cochran, Thad (Mary Henson); See, Jordan; Henry, Elizabeth (Cochran); Gaddis, Tara; Large, Patrick; Avant, Lanier; (Esther_Clark@burr.senate.gov); (Susan_Hatfield@burr.senate.gov); Abram, Anna (HELP Committee); Franklin, Margaret; Brown, Sandra; McClendon, Shaniqua; Thompson, Kristi (Gribble); Burr, Richard (Andrea_Davis@burr.senate.gov); Burr, Richard (Angela Boothe); Burr, Richard (Colin Rom); Britton, Cammie; Sills, Dennis; Taylor, Annette; Cooke, Jason; Bell, Preston; Bowlen, Joshua; Meek, Nancy; Enos, Zachary; Jelnicky, Michelle; Thrift, Laura; Blalock, Nora; Sanders, Kyle; Tillis, Thom (Matt Flynn); Tillis, Thom (Ray Starling); Stringer, Meghan; Heimbach, Joel; Palmer, Ashli; Patterson, Addie; Spencer, Nicholas; Graham, Lindsey (Jessica Phillips-Tyson); Graham, Lindsey (Nick Myers); Graham, Lindsey (Scott Graber); Binkholder, Natalee; Prianti, Marissa (L. Graham); Brooks, Courtney; Ouimette, Justin; Scott, Tim (Claire Brandewie); Scott, Tim (Will Holloway); Rich, Candace; Alexander, Lamar (Meeks, Brett); Mitchell, Katie; Toomey, Jon; Hippe, Jim; Wadkins, Randy; Goetz, Vic; Corker, Bob (Hayly Humphreys); Vaughn, Richard; Cohen, Lauren; DeBerry, Caroline; Eblen, Alex (Corker); Schrodt, Corey; Ingram, Conner; Lapinski, MarySumpter (HELP Committee); Osborn,

Sarah (Corker); Meyer, Matt

Cc: Chadwick, Alpheus K. (CMS/OL)

Subject: Hill Notification: CMS Proposes Hospital Outpatient Prospective Payment Changes to Better Support Physicians and Improve Patient Care

U.S. House and Senate Notification

Wednesday, July 6, 2016

To: Congressional Health Staff

From: Megan O'Reilly

Director, Office of Legislation

Centers for Medicare & Medicaid Services

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

Today, the Centers for Medicare & Medicaid Services (CMS) proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers.

The proposed rule would address physicians' and other health care providers' concerns that patient survey questions about pain management in the Hospital Value-Based Purchasing program unduly influence prescribing practices. CMS is proposing to remove the pain management dimension from the Hospital Value-Based Purchasing program to eliminate any potential financial pressure clinicians may feel to overprescribe pain medications.

In addition, CMS is proposing policies to implement section 603 of the Bipartisan Budget Act of 2015, which provides that certain items and services provided by certain hospital off-campus outpatient departments would no longer be paid under the OPPS. Further, CMS is supporting physicians and other providers through today's rule by increasing flexibility for hospitals and critical access hospitals that participate in the Medicare electronic health records (EHR) Incentive Program. These changes include a proposal for clinicians, hospitals, and critical access hospitals to use a 90-day EHR reporting period in 2016 – down from a full calendar year for returning participants.

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

The proposed rule can be downloaded from the Federal Register at: <https://www.federalregister.gov/public-inspection>.

The press release on this proposed rule will be available at this link:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-07-06.html>.

And the fact sheet on this proposed rule is available at this link:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-06.html>.

If you have any questions, please contact the CMS Office of Legislation. Thank you.

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Friday, July 15, 2016 10:12 AM
To: Newlin, Manda (CMS/OL)
Cc: Druckman, Jennifer (CMS/OL); Martino, Maria (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: RE: A couple simple MACRA questions

Thanks so much for the response!

Have a wonderful weekend,
Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

From: Newlin, Manda (CMS/OL) [mailto:Manda.Newlin@cms.hhs.gov]
Sent: Friday, July 15, 2016 9:50 AM
To: DiBlasio, Carla
Cc: Druckman, Jennifer (CMS/OL); Martino, Maria (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: RE: A couple simple MACRA questions

Hi Carla,

We wanted to get back to you about your MACRA-related questions.

- 1) **When will the MACRA comments become fully available for public consumption?**
The comments submitted in response to the MACRA proposed rule are publically posted here: <https://www.regulations.gov/docket?D=CMS-2016-0060>. To date, it appears there have been over 3,900 comments submitted.
- 2) **When does CMS plan to release the list of patient-facing encounter codes? Will it be before the final rule?**
As discussed in the MACRA proposed rule (81 FR 28174), we propose to define a non-patient-facing MIPS eligible clinician for MIPS at § 414.1305 as an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period. We consider a patient-facing encounter as an instance in which the MIPS eligible clinician or group billed for services such as general office visits, outpatient visits, and surgical procedure codes under the physician fee schedule. We intend to publish the proposed list of patient-facing encounter codes on a CMS Web site similar to the way we currently publish the list of face-to-face encounter codes for PQRS. We are still determining the timing as to when these codes would be published.
- 3) **Under MACRA, what percentage of the upside risk goes directly to the physician? In other words, if a physician successfully generates substantial savings under an advanced APM, does the physician get to keep any said savings?**
The amount of payments and/or savings that a physician receives under an Advanced APM would be determined by the terms and conditions specific to the Advanced APM. The proposed MACRA rule does not make any changes to the financial arrangements of any Advanced APMs (or APMs). The MACRA proposal provides that if a physician has sufficient payments or patients in an Advanced APM, then the physician would be excluded from MIPS adjustments and receive a 5% Medicare Part B incentive payment for the particular

payment year (81 FR 28294). At the same time, the physician would receive payments and/or savings through the Advanced APM as stipulated by the Advanced APM's terms and conditions.

We hope this information helps. Please let us know if you have any additional questions.

Thanks,
Manda

From: DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]
Sent: Monday, July 11, 2016 10:21 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: A couple simple MACRA questions

Hey Al,

I hope this email finds you well! A couple simple questions came up recently and my boss wanted me to check in with you. We'd greatly appreciate your response to the following questions:

- 4) MACRA comments for public consumption:
When will the MACRA comments become fully available for public consumption? It's our impression that only a few of the MACRA comments are currently posted online and folks were hoping to see all comments given the great importance of the proposed rule on MACRA implementation.

- 5) Clarifying and ensuring maximum flexibility for non-patient-facing physicians within the MIPS program:
Dr. Price requests that CMS disclose the list of non-patient facing codes before the release of the final MACRA rule. **When does CMS plan to release the list of codes? Will it be before the final rule?**

- 6) Shared savings for physicians under advanced APMS:
Under MACRA, what percentage of the upside risk goes directly to the physician? **In other words, if a physician successfully generates substantial savings under an advanced APM, does the physician get to keep any said savings?**

Thanks so much!
Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Friday, July 15, 2016 9:47 PM
To: Howell, Cherie A. (CMS/OL)
Cc: Lewandowski, David S. (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Innovation Center's Bundled Payments for Care Improvement Initiative and the Comprehensive Primary Care Plus Model.

My apologies, this makes sense. Please disregard my last email.

Have a great weekend!
Carla

From: DiBlasio, Carla
Sent: Friday, July 15, 2016 7:18 PM
To: 'Howell, Cherie A. (CMS/OL)'
Cc: Lewandowski, David S. (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Innovation Center's Bundled Payments for Care Improvement Initiative and the Comprehensive Primary Care Plus Model.

Thanks so much for the heads up on this.

Just one question:

What do you mean by this sentence? What does this mean exactly for the participants?

"CMS is being proactive in preventing unintended consequences for participants from any inaccuracies in payment methodologies while we take the time needed to fully understand this issue."

Thanks!

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

From: Howell, Cherie A. (CMS/OL) [<mailto:Cherie.Howell@cms.hhs.gov>]
Sent: Friday, July 15, 2016 3:50 PM
To: DiBlasio, Carla
Cc: Lewandowski, David S. (CMS/OL); Chadwick, Alpheus K. (CMS/OL)
Subject: Innovation Center's Bundled Payments for Care Improvement Initiative and the Comprehensive Primary Care Plus Model.

We wanted to provide you with some updates on the Innovation Center's Bundled Payments for Care Improvement Initiative and the Comprehensive Primary Care Plus Model.

Bundled Payments for Care Improvement (BPCI) Initiative

CMS has been working with BPCI Awardees and our contractors to resolve a provider reassignment and episode attribution issue that has been affecting BPCI. It came to CMS' attention that the Physician Group Practice (PGP)

Reassignment Lists distributed to BPCI Awardees and used by the reconciliation contractor to attribute episodes to PGPs contained errors that resulted in episodes being attributed to PGPs that should not be and episodes not being attributed to PGPs that should be. This issue only affects BPCI Models 2 and 3.

CMS has decided it expects to offer an amendment to the BPCI Model Agreement to affected Awardees that would eliminate downside risk for episodes for all PGP Awardees and PGP Episode Initiators for all of 2015. Furthermore, we expect that the amendment would eliminate downside risk for any non-PGP Awardees and Episode Initiators with an episode of care that is negatively impacted by the episode attribution issues in the affected time period. In taking this action, CMS is being proactive in preventing unintended consequences for participants from any inaccuracies in payment methodologies while we take the time needed to fully understand this issue. CMS is continuing to review the data and information, and is considering additional short term and long term solutions to resolve these issues.

The BPCI initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. For more information on the BPCI initiative, please visit: <https://innovation.cms.gov/initiatives/bundled-payments/>.

Comprehensive Primary Care Plus Model (CPC+)

CMS expects to announce the CPC+ regions by the end of July. CPC+ is expected to take place in up to 20 regions. The practice application is anticipated to open August 1 through September 15, 2016.

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ is a five-year multi-payer model that will begin in January 2017. More information about the model is available at: <https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus>.

Please let us know if you have any questions.

Chadwick, Alpheus K. (CMS/OL)

From: Puchalla (Creitz), Charlene <Charlene.Puchalla@mail.house.gov>
Sent: Monday, July 25, 2016 3:55 PM
To: Chadwick, Alpheus K. (CMS/OL); DiBlasio, Carla
Cc: Howell, Cherie A. (CMS/OL); Dugan, Meghan
Subject: RE: Rep. Price (GA) Call w/Dr. Conway

Sure thing. Glad it will work out. I'll let him know about the background noise, but no worries!

Thanks for your help!

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Monday, July 25, 2016 3:53 PM
To: Puchalla (Creitz), Charlene; DiBlasio, Carla
Cc: Howell, Cherie A. (CMS/OL); Dugan, Meghan
Subject: RE: Rep. Price (GA) Call w/Dr. Conway

Hello Carla and Charlene --

Yes, this works for Patrick; 5:00pm EST today. And please note that Patrick is out with family so there might be some kid noise in the background, but Patrick wanted to reach Dr. Price today. Thanks for all your help on short notice.

-Al

From: Puchalla (Creitz), Charlene [mailto:Charlene.Puchalla@mail.house.gov]
Sent: Monday, July 25, 2016 3:34 PM
To: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>; Dugan, Meghan <Meghan.Dugan@mail.house.gov>
Subject: RE: Rep. Price (GA) Call w/Dr. Conway

Thanks, Carla.

Hi Al,

I'm happy to work with you regarding a call with Congressman Price. He's available at 5:00 PM EST today. If this works, let's use the following conference line:

Call-in#:
Guest Code:

Thanks!

From: DiBlasio, Carla
Sent: Monday, July 25, 2016 3:22 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Cc: Howell, Cherie A. (CMS/OL); Dugan, Meghan; Puchalla (Creitz), Charlene
Subject: RE: Rep. Price (GA) Call w/Dr. Conway

Thanks so much for your email, Al.

We greatly appreciate you reaching out to our office. We are short staffed at the moment, so I've been trying to track down a workable time. Let me loop in the Congressman's district scheduler, as well.

Thanks again!

Carla

From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]

Sent: Monday, July 25, 2016 3:18 PM

To: DiBlasio, Carla

Cc: Howell, Cherie A. (CMS/OL); Dugan, Meghan

Subject: Rep. Price (GA) Call w/Dr. Conway

Hello Carla – as a follow-up to our conversation, I was asked to reach out to you about arranging a call this afternoon between Congressman Price and Dr. Patrick Conway, CMS Principle Deputy Administrator regarding a Medicare-related announcement we will be making soon. Can you please let me know Congressman Price's availability today after 4:15pm EST. Thanks.

Al Chadwick

Office of Legislation/Congressional Affairs Group

Centers for Medicare & Medicaid Services

200 Independence Ave, SW

Room 351G

Washington, DC 20201

202-690-5519 (Phone)

202-690-8168 (Fax)

alpheus.chadwick@cms.hhs.gov

Chadwick, Alpheus K. (CMS/OL)

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Wednesday, August 3, 2016 3:52 PM
To: Dugan, Meghan
Cc: DiBlasio, Carla; Martino, Maria (CMS/OL); Howell, Cherie A. (CMS/OL)
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Hello Meghan –

As a follow-up to our conversation, Andy and Dr. Conway are not available below August 23rd to tour with Congressman Price. Please let me know if the Congressman has any availability in September. Thanks.

-Al

From: Dugan, Meghan [mailto:Meghan.Dugan@mail.house.gov]
Sent: Monday, August 1, 2016 10:06 AM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Al,

I am so sorry to say but we had an issue arise for our tour time on the 23rd. Is there anyway Dr. Price may be able to tour CMS on either the 16th or 17th?

Meghan

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Monday, July 25, 2016 3:21 PM
To: DiBlasio, Carla
Cc: Howell, Cherie A. (CMS/OL); Martino, Maria (CMS/OL); Dugan, Meghan
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Hello Carla – I want to circle back to ask if there was a particular area of interest to the Congressman during his tour? Thanks.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Tuesday, July 19, 2016 4:29 PM
To: 'Dugan, Meghan' <Meghan.Dugan@mail.house.gov>
Cc: Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>; DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>; Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Hello Meghan – thank you very much for your cooperation, and we have the visit confirmed on our end for Tuesday, 8/23 from 10:00-11:30 at our CMS Headquarters in Baltimore.

Al

From: Dugan, Meghan [<mailto:Meghan.Dugan@mail.house.gov>]
Sent: Tuesday, July 19, 2016 4:09 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>; DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

That will work fine thank you Al.

From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]
Sent: Monday, July 18, 2016 5:05 PM
To: Dugan, Meghan
Cc: Howell, Cherie A. (CMS/OL); DiBlasio, Carla
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Hello Meghan – I am sorry I am only now seeing your response. Unfortunately, the only date/time that Andy and Dr. Patrick have is Tuesday, 8/23 10:00-11:30. Will that work for Dr. Price? If not, please suggest other dates/times that may work.

Al Chadwick
Office of Legislation/Congressional Affairs Group
Centers for Medicare & Medicaid Services
200 Independence Ave, SW
Room 351G
Washington, DC 20201
202-690-5519 (Phone)
202-690-8168 (Fax)
alpheus.chadwick@cms.hhs.gov

From: Dugan, Meghan [<mailto:Meghan.Dugan@mail.house.gov>]
Sent: Tuesday, June 21, 2016 4:00 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>; DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Cc: Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Al,

I was able to secure a time for Dr. Price to come and tour the facility. Will 12:30-2:00 still work for your schedule?

Meghan

From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]
Sent: Tuesday, June 21, 2016 10:42 AM
To: Dugan, Meghan; DiBlasio, Carla
Cc: Howell, Cherie A. (CMS/OL)
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Hello Meghan – thx and please let me know because I don't know how long I can hold these dates/times. Also, do let me know if there are other dates/times when Dr. Price is available in August.

-Al

From: Dugan, Meghan [<mailto:Meghan.Dugan@mail.house.gov>]
Sent: Tuesday, June 21, 2016 10:26 AM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>; DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Cc: Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Al,

Thanks for reaching back out. I'm not sure if Dr. Price is slated to be up here during that week in August so I will be back with you shortly when I know for sure.

Thank you!
Meghan

From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]
Sent: Monday, June 20, 2016 2:26 PM
To: DiBlasio, Carla
Cc: Dugan, Meghan; Howell, Cherie A. (CMS/OL)
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Hello Carla & Meghan –

I want to provide you with dates/times that Andy Slavitt, CMS Acting Administrator, and Dr. Patrick Conway, Principle Deputy Administrator are available:

Monday, 8/22 1-2:30 again between 3:00-5:00pm
Tuesday, 8/23 10:00-11:30 and 12:30-2:00pm

Can you please let us know which of these dates/times work for Congressman Price to visit? Thanks.

-Al

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Monday, June 13, 2016 7:42 AM
To: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Cc: Dugan, Meghan <Meghan.Dugan@mail.house.gov>; Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>
Subject: RE: Request for Congressman Price to visit your Baltimore HQ

Hello Carla – hope you had a great weekend. I will bring this request before my leadership. Is there a particular area of interest to the Congressman? Thanks.

-Al

From: DiBlasio, Carla [<mailto:Carla.Diblasio@mail.house.gov>]
Sent: Friday, June 10, 2016 6:15 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Dugan, Meghan <Meghan.Dugan@mail.house.gov>
Subject: Request for Congressman Price to visit your Baltimore HQ

Hey Al,

I hope this email finds you well. I wanted to put you in touch with our scheduler, Meghan Dugan. Congressman Price is very interested in visiting CMS headquarters in August this summer. Would a tour and meeting be possible? He's never been on site and would love to make a visit.

Thanks so much, and have a great weekend!

Carla

Carla DiBlasio
Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501



Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Sent: Monday, September 26, 2016 2:33 PM
To: Chadwick, Alpheus K. (CMS/OL)
Subject: RE: Can we chat on Monday?

Perfect, will do!

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Monday, September 26, 2016 2:32 PM
To: DiBlasio, Carla
Subject: RE: Can we chat on Monday?

4pm works for me...can you call me on 202-690-5519. Thx.

-Al

From: DiBlasio, Carla [mailto:Carla.Diblasio@mail.house.gov]
Sent: Monday, September 26, 2016 1:58 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: RE: Can we chat on Monday?

I can also do 4 pm if that's better for you

Thanks!

From: DiBlasio, Carla
Sent: Monday, September 26, 2016 1:57 PM
To: 'Chadwick, Alpheus K. (CMS/OL)'
Subject: RE: Can we chat on Monday?

Thanks for your patience, Al!

I won't take too much of your time. Does a quick call at 3:30 pm work?

What is your preferred number? Otherwise, feel free to call me at 202-225-4501

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Monday, September 26, 2016 12:41 PM
To: DiBlasio, Carla
Subject: RE: Can we chat on Monday?

Yes, what time works for you?

From: DiBlasio, Carla [mailto:Carla.Diblasio@mail.house.gov]
Sent: Monday, September 26, 2016 12:24 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: RE: Can we chat on Monday?

Hey Al,

My apologies, I was dragged into meetings this AM. Are you available at all this afternoon?

Thanks!

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]
Sent: Monday, September 26, 2016 10:26 AM
To: DiBlasio, Carla
Subject: RE: Can we chat on Monday?

Hello Carla – are you free at 10:30?

From: DiBlasio, Carla [<mailto:Carla.Diblasio@mail.house.gov>]
Sent: Friday, September 23, 2016 5:26 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: Can we chat on Monday?

Hey Al!

I hope this email finds you well. I need to chat with you about a couple items. I won't take much of your time. Do you have time for a quick call on Monday? Let me know a good time for you.

Thanks!

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Friday, September 30, 2016 9:54 AM
To: Chadwick, Alpheus K. (CMS/OL)
CC: Beck, Gary; Howell, Cherie A. (CMS/OL)
Subject: RE: CMMI Letter

Thanks so much, Al!

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Friday, September 30, 2016 8:04 AM
To: DiBlasio, Carla
Cc: Beck, Gary; Howell, Cherie A. (CMS/OL)
Subject: RE: CMMI Letter

Hello Carla – I'll make sure this letter gets to the right folks.

-Al

From: DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]
Sent: Thursday, September 29, 2016 5:33 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Beck, Gary <Gary.Beck@mail.house.gov>
Subject: CMMI Letter

By Al!

Please find attached a letter to CMS signed by Congressman Price and 178 additional Members of Congress. Our letter urges that CMMI stop experimenting with Americans' health and cease all mandatory demos. Additionally, we direct CMMI to ensure that future models comply with current law, including appropriate limitations on the size and scope of the models and not expanding models without Congressional approval.

Thanks!
Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

Congress of the United States
Washington, DC 20515

September 29, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Patrick Conway, M.D., MSc
Deputy Administrator, Innovation & Quality
Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt and Dr. Conway,

The Center for Medicare and Medicaid Innovation (CMMI) is charged with testing and evaluating voluntary healthcare payment and service delivery models with the intent of increasing quality and efficiency while reducing program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).¹ However, as evidenced by three recently proposed mandatory models, CMMI has exceeded its authority, failed to engage stakeholders, and has upset the balance of power between the legislative and executive branches.² What makes these proposals even more disconcerting is their potentially negative effects on patients, especially our vulnerable seniors. Policies that have the potential to create access issues for beneficiaries, further provider consolidation, and reduce provider participation in Medicare can drastically deteriorate quality of care our seniors rely on. This would be a step backwards in our unified effort to move to higher quality, more value-based care for our nation's seniors. We ask that you cease all current and future planned mandatory initiatives under the CMMI.

Until recently, the tests and models developed by CMMI were implemented, as intended, on a voluntary, limited-scale basis where no state, healthcare provider, or health insurer had any obligation to participate. However, on November 24th, 2015, the Centers for Medicare and Medicaid Services (CMS) published a final rule requiring at least 800 hospitals in 67 geographical areas selected by CMS to participate in a new bundled payment model for hip and knee replacements, the Comprehensive Care Joint Replacement (CJR) Model.³ Furthermore, on March 8th, 2016, CMS released a proposed rule that requires thousands of providers across the country to comply with a new drug payment model under Part B of Medicare.^{4,5} The proposed Part B Drug Payment Model is a clear example of the CMMI's overstep of authority, given the mandatory participation required of thousands of providers and millions of patients with serious conditions and rare diseases on a

¹ Social Security Act Sec. 1115A(a).

² CMS bases its authority for the Part B Proposal on Section 1115A, which can be viewed as an unconstitutional delegation of legislative power. Article I, Section 1 of the Constitution prohibits Congress from delegating its legislative powers to other bodies, including executive agencies like CMS. See *Whitman v. Am. Trucking Assn's*, 531 U.S. 457, 472 (2001).

³ 80 Federal Register 73274, November 24, 2015.

⁴ 81 Federal Register 13230, March 11, 2016.

⁵ The Demonstration Program would change reimbursement practices for 75 percent of the country.

near-nationwide scale. Most recently, on July 25th, 2016, CMS announced the Cardiac Bundled Payment Model (Cardiac Models) that forces one quarter of all metropolitan areas across the nation into bundled payments for certain severe cardiac conditions and expands the controversial CJR Model to include more hip services.⁶ In contravention of the statute, these CMMI models were developed absent input from impacted stakeholders and fail to include safeguards to protect the delicate balance of quality, cost, and access to care for beneficiaries. These mandatory models overhaul major payment systems, commandeer clinical decision-making, and dramatically alter the delivery of care.

By focusing solely on cost-savings without adequate regard to the detrimental effects that the CJR Model, Part B Drug Payment Model, and Cardiac Models may potentially have, CMS at best has heeded only part of its statutory duty—“reduc[ing] program expenditures”—at the expense of its other duties—“preserving or enhancing the quality of care.”⁷ However, a 2015 blog post by the Congressional Budget Office would suggest that CMMI’s demonstrations do not in fact reduce costs, stating that they have “not yet yielded noticeable savings.”^{8,9} In addition to failing to cut costs, mandating participation in large scale demonstrations could have the opposite effect of “preserving or enhancing the quality of care.”¹⁰ We are aware that some models tested under demonstration programs fail to produce quality improvements and anticipated cost savings. This is why the statute authorized the Secretary to “test innovative payment and service delivery models”¹¹—not *mandate* them for all providers in designated geographical areas. CMMI’s mandatory models “experiment” with thousands of patient lives without prior testing on a smaller scale or even a basic indication that they will actually achieve improved quality or, at the very least, maintain present quality.

CMMI has failed to meet its statutory requirements for implementing models, including starting with a limited, “Phase I” test, engaging stakeholders in model development, and describing the “defined population” and “deficits in care”¹² the model seeks to address. As a result, Medicare providers and their patients are blindly being forced into high-risk government-dictated reforms with unknown impacts. Any true medical experiment requires patient consent. However, patients residing in an affected geographical area will have no choice about their participation.

As elected Representatives of our constituents and patients who will be directly impacted by these CMMI models or “experiments,” we are limited in our rightful ability to act on behalf of our constituencies to alter, delay or upend these mandatory demonstration programs. CMS’ Part B proposal, for example, would rewrite Medicare Part B payment law in 75 percent of the country without going through the Constitutional procedures where legislation is debated and approved in

⁶See proposal on July 25, 2016 at <https://innovation.cms.gov/Files/x/advancing-care-coordination-nprm.pdf>

⁷ 42 U.S.C. § 1315a(a).

⁸ *Estimating the Budgetary Effects of Legislation Involving the Center for Medicare and Medicaid Innovation*, Congressional Budget Office

⁹ CBO reiterated the contents of the blogpost in testimony before the House Budget Committee on September 7th, 2016. (Mark P. Hadley, *CBO’s Estimates of the Budgetary Effects of the Center for Medicare & Medicaid Innovation*, testimony before the Committee on the Budget, U.S. House of Representatives, 7 September 2016)

¹⁰ As Justice Scalia cautioned, “*Chevron* allows agencies to choose among competing reasonable interpretations of a statute; it does not license interpretive gerrymanders under which an agency keeps parts of statutory context it likes while throwing away parts it does not.” *Michigan v. EPA*, 576 U.S. ___ (2015), slip op. 9 (citing *Chevron v. NRDC*, 467 U.S. 837 (1984)).

¹¹ 42 U.S.C. § 1315a(a)(1) (emphasis added).

¹² Social Security Act Sec. 1115A(b)(2)(A).

both chambers of Congress, and subsequently signed by the President. These most basic tenets of our government, intended by our Founding Fathers to preserve and maintain balance of power, have clearly been neglected. CMMI interprets their authority to "test" innovative models on a limited basis as a means to substantially alter both the delivery and reimbursement of care without any input or approval from Congress and the constituents we represent.

Accordingly, we insist CMMI stop experimenting with Americans' health, and cease all current and future planned mandatory initiatives within the CMML. Additionally, we ask that you commit to ensuring future CMMI models fully comply with current law, including: limiting the size and scope of CMMI demonstrations so they represent true tests rather than wholesale changes to statute; seeking Congressional approval if expansion of test models require changes to the underlying statute; and establishing an open, transparent process that supports clear and consistent communication with physicians, patients and other relevant stakeholders in the development of new CMMI models.

We look forward to your response detailing next steps as to how the agency plans to ensure that the CMMI will cease current mandatory initiatives and refrain from pursuing any future initiatives that exceed CMMI's scope of authority.

Sincerely,




Tom Price, M.D.
Member of Congress



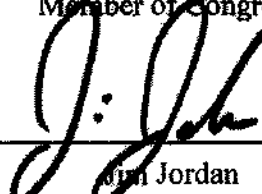
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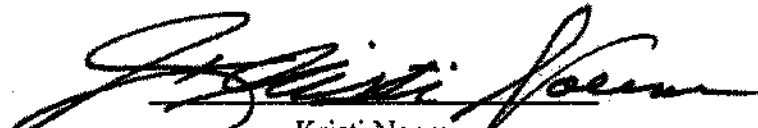

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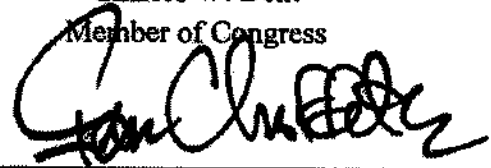
Ken Calvert
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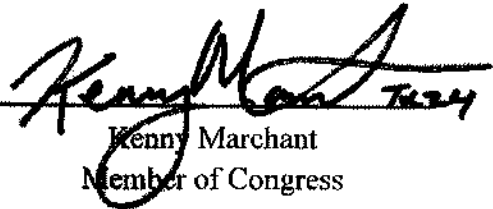
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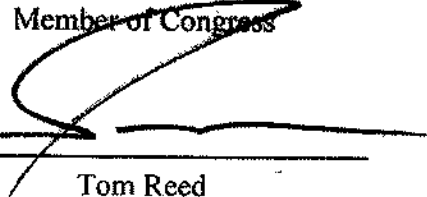
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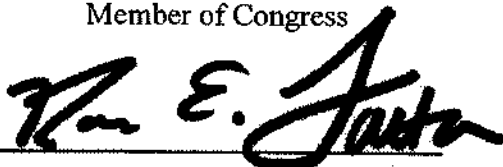
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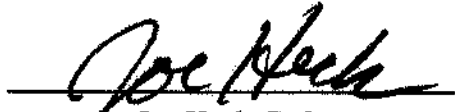
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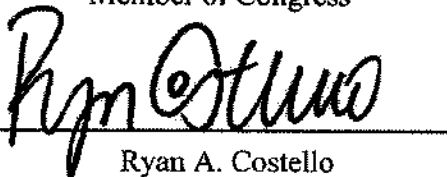
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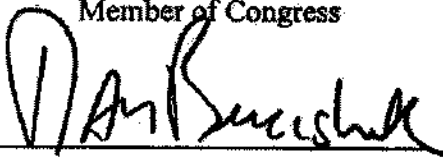
Richard Hudson
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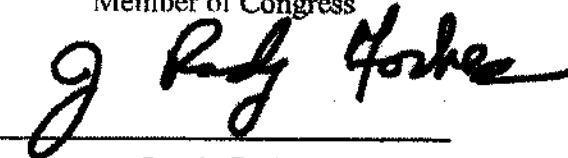
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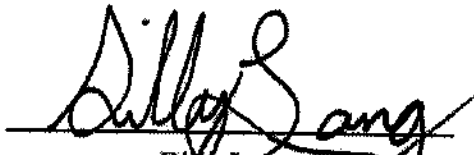
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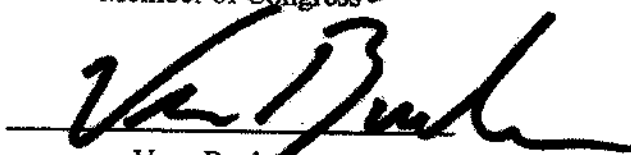
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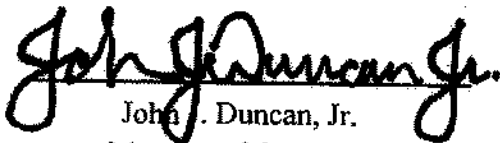
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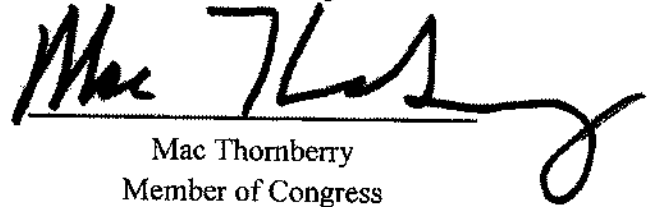

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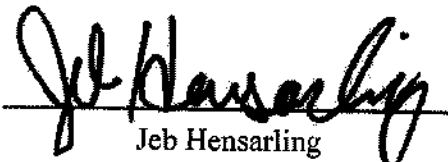

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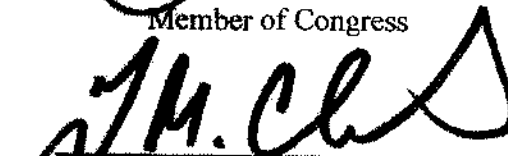

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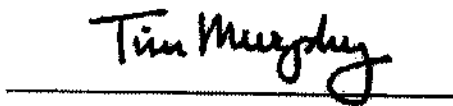

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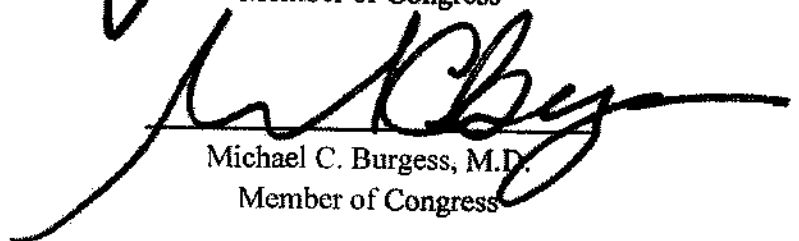

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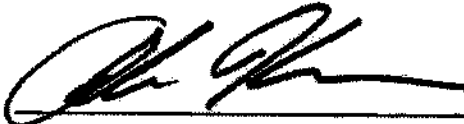

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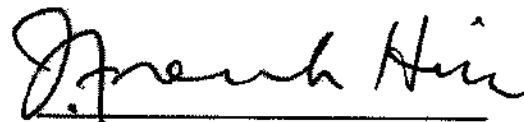

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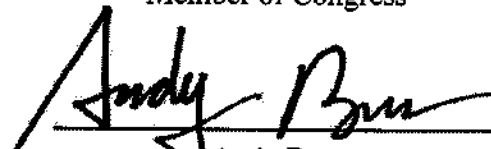

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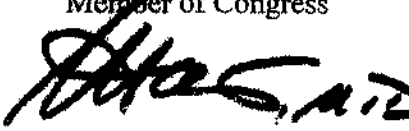

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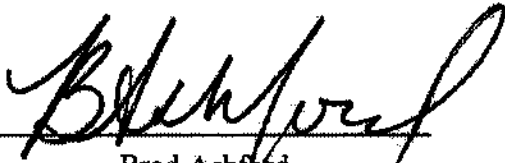

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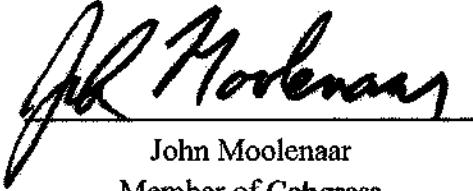

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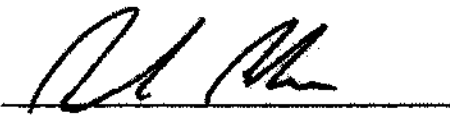
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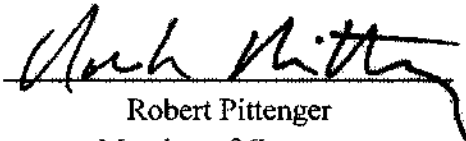
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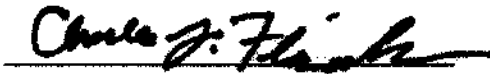
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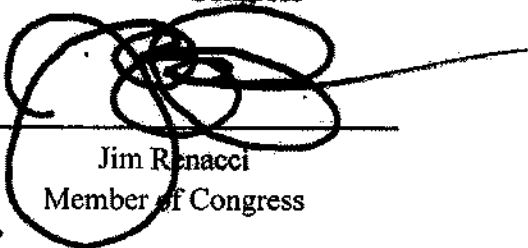
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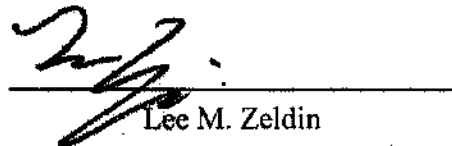
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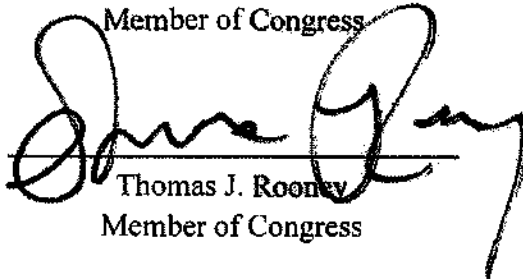
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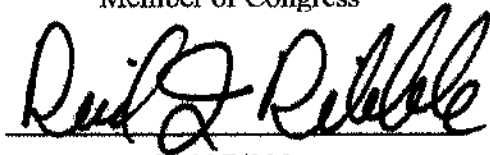
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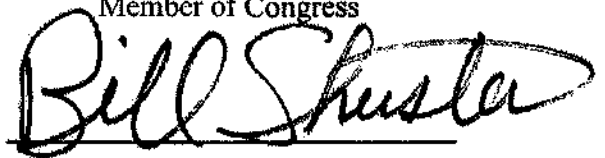
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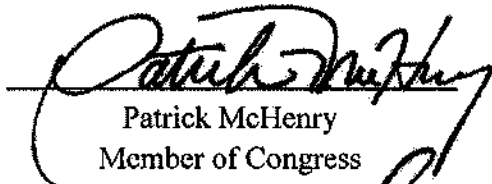
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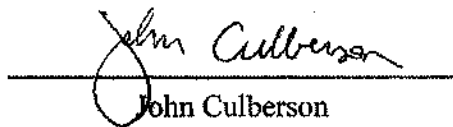
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Bill Shuster
Member of Congress



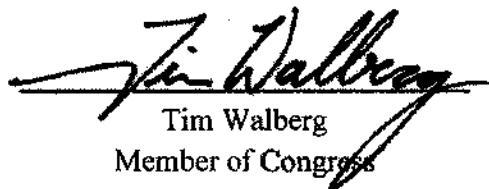
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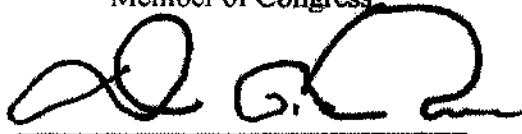
Austin Scott
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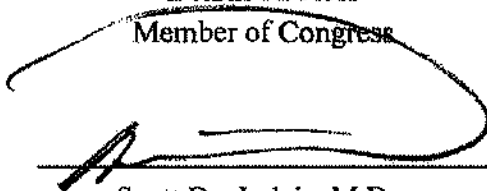
Tim Walberg
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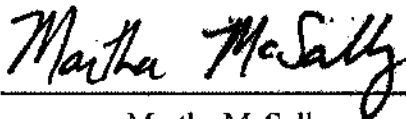
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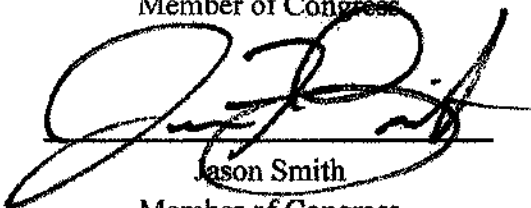
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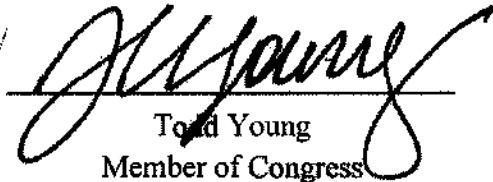
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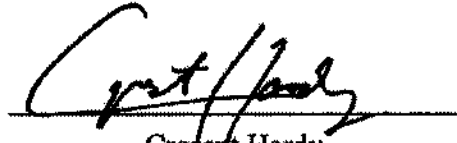
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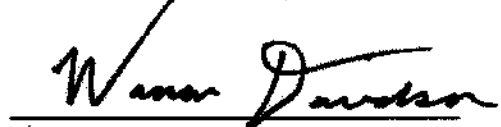
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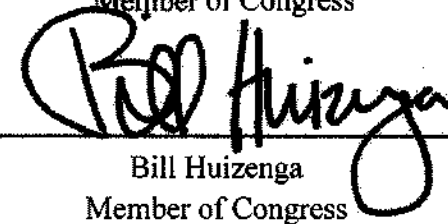
Crescent Hardy
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David Young
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Warren Davidson
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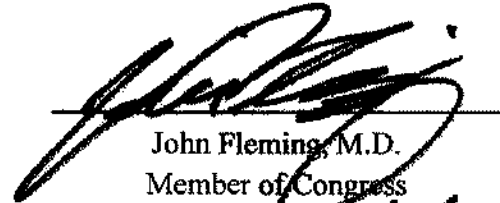
Bill Huizenga
Member of Congress



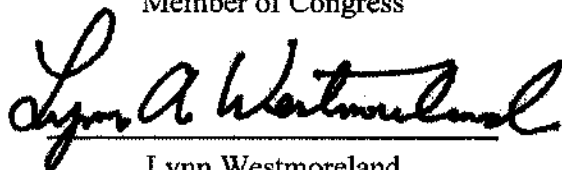
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John Fleming, M.D.
Member of Congress



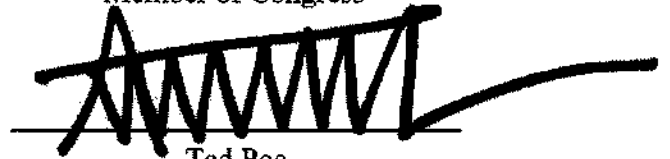
Lynn Westmoreland
Member of Congress



Steve King
Member of Congress



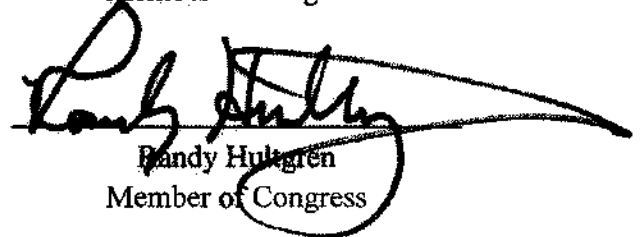
Darrell Issa
Member of Congress



Ted Poe
Member of Congress



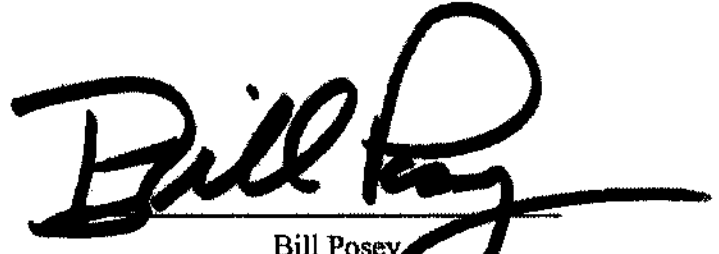
Blaine Luetkemeyer
Member of Congress



Randy Hultgren
Member of Congress



Jeff Duncan
Member of Congress



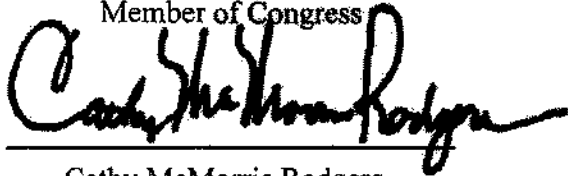
Bill Posey
Member of Congress



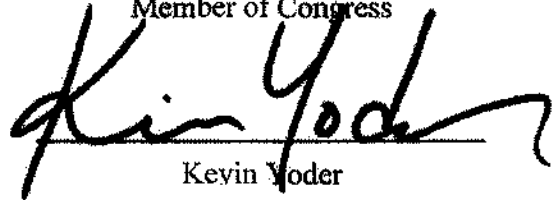
Rob Bishop
Member of Congress



Michael T. McCaul
Member of Congress



Cathy McMorris Rodgers
Member of Congress



Kevin Yoder
Member of Congress



Mia Love
Member of Congress



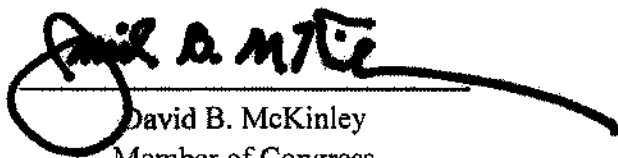
Barry Loudermilk
Member of Congress



Thomas Massie
Member of Congress



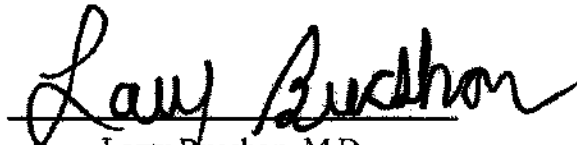
Dave Brat
Member of Congress



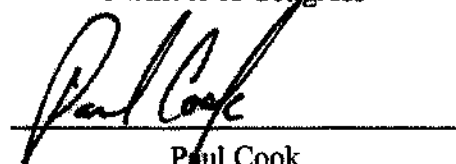
David B. McKinley
Member of Congress



Tom Emmer
Member of Congress



Larry Bucshon, M.D.
Member of Congress



Paul Cook
Member of Congress



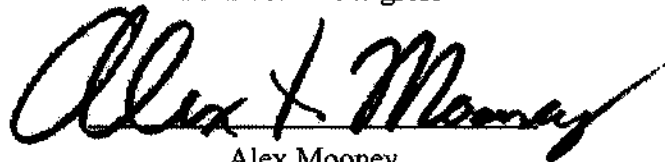
Ryan Zinke
Member of Congress



Scott Tipton
Member of Congress



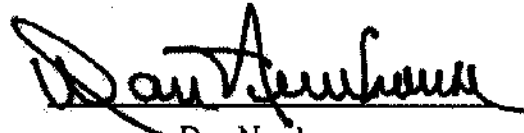
Tom MacArthur
Member of Congress



Alex Mooney
Member of Congress



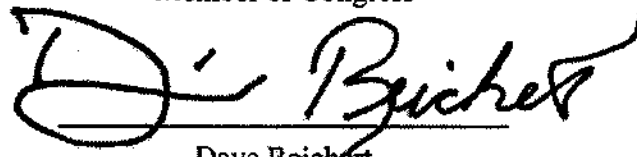
Doug Collins
Member of Congress



Dan Newhouse
Member of Congress



Rob Woodall
Member of Congress



Dave Reichert
Member of Congress

Chadwick, Alpheus K. (CMS/OL)

From: Puchalla (Creitz), Charlene <Charlene.Puchalla@mail.house.gov>
Sent: Friday, September 30, 2016 2:51 PM
To: Chadwick, Alpheus K. (CMS/OL); DiBlasio, Carla
Cc: Dugan, Meghan; Martino, Maria (CMS/OL); Howell, Cherie A. (CMS/OL)
Subject: RE: Request for a phone call w/ Congressman Price re: global codes

Thank you very much!

We're confirmed for Monday, October 3rd at 3:30 PM. Carla will be joining Congressman Price on the call, as well.

Thank you,
Charlene

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Friday, September 30, 2016 2:50 PM
To: Puchalla (Creitz), Charlene; DiBlasio, Carla
Cc: Dugan, Meghan; Martino, Maria (CMS/OL); Howell, Cherie A. (CMS/OL)
Subject: RE: Request for a phone call w/ Congressman Price re: global codes

Hello Charlene –

Sean Cavanaugh, CMS Deputy Administrator and Director of the Center for Medicare is available to speak with Dr. Price on Monday, Oct 3 at 3:30pm EST. To access the call, dial [redacted] and when prompted Meeting Number: [redacted]. Please let me know if you have any questions. Thanks.

-Al

From: Puchalla (Creitz), Charlene [mailto:Charlene.Puchalla@mail.house.gov]
Sent: Friday, September 30, 2016 11:34 AM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>; DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Cc: Dugan, Meghan <Meghan.Dugan@mail.house.gov>; Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>; Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>
Subject: RE: Request for a phone call w/ Congressman Price re: global codes

Sounds great. Thanks!

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Friday, September 30, 2016 11:14 AM
To: Puchalla (Creitz), Charlene; DiBlasio, Carla
Cc: Dugan, Meghan; Martino, Maria (CMS/OL); Howell, Cherie A. (CMS/OL)
Subject: RE: Request for a phone call w/ Congressman Price re: global codes

Hello Carla and Charlene –

I am checking respective schedules of folks here and will follow-up asap.

From: Puchalla (Creitz), Charlene [mailto:Charlene.Puchalla@mail.house.gov]
Sent: Friday, September 30, 2016 10:23 AM
To: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>; Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Dugan, Meghan <Meghan.Dugan@mail.house.gov>
Subject: RE: Request for a phone call w/ Congressman Price re: global codes

Thanks Carla!

Hi Al,

Congressman Price has availability on Monday, October 3rd between 3-5:00 PM. If you are available, we can schedule a call in that timeframe; otherwise, we can look at an alternative date.

Thanks,
Charlene

From: DiBlasio, Carla
Sent: Friday, September 30, 2016 10:21 AM
To: 'alpheus.chadwick@cms.hhs.gov'
Cc: Dugan, Meghan; Puchalla (Creitz), Charlene
Subject: Request for a phone call w/ Congressman Price re: global codes

Hey Al,

I am following up on our conversation earlier this week regarding global codes. I spoke with Dr. Price and he has serious concerns about CMS's proposal to collect data from *all* physicians who perform 10- and 90-day global codes using the 8 newly created G-codes. It is impractical for physicians to comply with this requirement, especially since the proposal tails using G-codes in 10-minute increments. The proposal is untenable for a practicing surgeon for many reasons.

Dr. Price would like to arrange a call with the appropriate agency head, perhaps Mr. Slavitt or Mr. Conway, to discuss this proposal. As always, we greatly appreciate your help in facilitating. Meghan Dugan and Charlene Puchalla (copied) handle the Congressman's schedule in both DC and GA. I know they would be happy to work with you to find a time that works best on your end.

Thanks again, and have a wonderful weekend!

Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, October 6, 2016 2:41 PM
To: Chadwick, Alpheus K. (CMS/OL)
CC: Zebley, Kyle; Howell, Cherie A. (CMS/OL)
Subject: Re: MACRA Letter to CMS

Thanks, Al!

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

On Oct 6, 2016, at 2:15 PM, Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov> wrote:

Hello Carla – I will make sure this letter gets to the right folks here.

-Al

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Thursday, October 6, 2016 2:04 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
CC: Zebley, Kyle <Kyle.Zebley@mail.house.gov>
Subject: MACRA Letter to CMS

Hey Al,

Please find attached a copy of a letter to CMS regarding MACRA implementation concerns. It is signed by Members of the Congressional Doctors Caucus.

We greatly appreciate your attention to this matter and look forward to your response.

Thanks so much!

Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

Congress of the United States
Washington, DC 20515

October 6, 2016

The Hon. Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Hon. Shaun Donovan
Director
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Dear Acting Administrator Slavitt and Director Donovan:

On April 27th, CMS released a proposed rule to implement the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. By repealing the Sustainable Growth Rate Formula, MACRA has the potential to transform the healthcare landscape and the delivery of care. However, if CMS implements the rule in a manner which is inconsistent with Congressional intent, MACRA has the potential to overcomplicate an already burdensome and complex quality reporting system and take more time away from patient care.¹

According to a *Health Affairs* study published in March of 2016, physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion each year on quality measure reporting programs. Furthermore, the majority of time spent on quality reporting consists of "entering information into the medical record only for the purpose of reporting quality measures from external entities," and nearly three-quarters of practices stated their group was being evaluated on quality measures that were not clinically relevant. Congress recognized that these programs may actually detract from quality care by driving providers' time away from patients, and, as a result, replaced them with what is supposed to be a streamlined quality program, known as the Merit-based Incentive Payment System (MIPS).

Under MACRA, providers will use either MIPS or an advanced alternative payment model (APM). In an impact analysis within its proposed MACRA implementation rule, CMS projects that as few as 6% of physicians may participate in qualified APMs. While we believe there are ways to expand the APM option to more physicians, it is clear that the vast majority of physicians will be reporting under MIPS in 2017. Given the immediate focus on MIPS, we are particularly concerned about the complexity of MIPS, the timing of the performance period, and the significant impact of the MIPS program on small and rural practices, among other issues.

We urge you to carefully address a number of multi-layered, high-level concerns that will likely require multi-faceted solutions. Thus, we encourage the agency to take note of the technical issues being presented in the comment letters of the various providers, specialty physicians and medical industry stakeholders.

MACRA brings significant changes to physician workflows, yet most physicians remain entirely

¹ According to a survey released in July of 2016 by Deloitte, 74% of physicians already find quality reporting to be burdensome.

unaware of MACRA or its implications. Deloitte recently surveyed 600 primary care and specialty physicians regarding MACRA. Of those surveyed, 50% of physicians reported that they have never heard of MACRA, and an additional 32% said that they have heard of it but are unfamiliar with its requirements. Thus, 82% of physicians are unaware of how their reimbursement will be impacted by this new law. Following publication of the final rule and ahead of the start date, the agency must devote significant resources to educate practices about MACRA.

MIPS is Too Complex

As proposed, even the smallest physician group practices (10 or fewer eligible professionals) would need to expend finite resources on measuring and monitoring their performance on at least 22 measures, including a minimum of eight measures in the quality category, at least two measures in resource use, at least 11 measures in ACI, and at least one measure in the clinical practice improvement activity (CPIA) category.² In order to be successful, MIPS must engage clinicians with a reporting system that is not overly burdensome, a scoring system that is simple and transparent, attainable thresholds, and a short enough quality/payment feedback loop to allow physicians to learn and make necessary changes to avoid further penalty.

More detailed feedback reports are needed to assist physicians in understanding their performance rating, including the specific cause for a penalty assessment, the reporting rate for each measure, the calculation methodology and any errors in received data. A transparent process with detailed reports will aid providers to more quickly rectify inaccuracies in their data, and enhance their ability to submit timely appeals before payment reductions are applied and performance ratings are made public. In the past, eligible professionals were left to decipher this rationale on their own, taking valuable time and resources away from patient care.

Within the same vein, an appeals process that is transparent and not administratively burdensome should be readily available to physicians throughout MIPS. An appeals process should have a reasonable time frame for providers to participate, especially given that MIPS will be new to all providers. An appeals process should also promptly address provider concerns with explicit timetables for review.

Start and Length of Performance Reporting Are Unrealistic

The proposed rule requires MIPS performance measurement to start on January 1, 2017, with the first MIPS payment adjustments being made in January 2019. Physicians and the organizations that represent them have expressed the widely-shared view that the timeline is unrealistic, prompting a recent announcement that CMS intends to give physicians considerable flexibility on when and how they meet MIPS participation requirements in 2017. We share the timeline concerns expressed by our physician colleagues and are encouraged that CMS appears to be taking a step in the right direction. We await further details to determine the extent to which this proposal and other provisions in the final rule alleviate potential problems raised by a 2017 start date. Specifically, we want to be sure that physicians have time to prepare with sufficient notice of program requirements in the final rule and a final list of qualified Advanced APMs.

We also ask CMS to adopt a 90-day reporting period, rather than the year-long period called for in the proposed rule, for the Advancing Care Information (ACI) category of MIPS to enable more small practices to succeed. Especially in the initial years of MIPS, a shorter reporting period is necessary

² Larger practices would have two additional CPIA measures and one additional quality measure.

for all providers, but particularly smaller practices who have fewer resources to keep up with the changing regulatory environment. A shorter reporting period would ensure that more providers are able to successfully make the transition to MIPS, upgrade their EHR technology and meet the new Stage 3 measures by 2018.³

The Impact of the MIPS Program on Small and Rural Practices will Continue to Drive Consolidation

According to the aforementioned Deloitte study, 58% of physicians say MIPS would encourage them to be part of a larger organization to reduce individual increased financial risk and have access to supporting resources and capabilities. In fact, 80% of surveyed physicians believe MACRA will drive consolidation.

To help reduce administrative burden for small practices and allow for flexibility in quality reporting, CMS should lower its patient minimum reporting thresholds. CMS proposed that providers using a registry must report quality measures on 90% of their patients from all payers, and 80% of Medicare patients for those reporting by claims. This is a significant jump from what is currently 50% of Medicare patients. Such a high minimum threshold would be impossible for many physicians, particularly those in small practices, to meet. We recommend that CMS maintain the minimum threshold at a maximum of 50% of Medicare patients.

Additionally, the MACRA statute included the concept of virtual groups to help assist small practices; however, CMS proposes not to implement virtual groups until the 2018 performance period. The newly-announced participation flexibility policy in 2017 may make this delay more acceptable. However, we strongly urge CMS to act swiftly on forming these groups as soon as possible to ensure that this option is communicated to physicians early enough to provide them with sufficient time to organize and participate. Without this assistance, we believe small practices face even greater challenges when attempting to adapt to the MIPS program structure.

CMS should also broaden its MIPS exclusion for providers who treat a low volume of Medicare patients. To help mitigate adverse effects on small practices, CMS has proposed a low-volume threshold that would exempt physicians from MIPS if their practice has less than \$10,000 in Medicare allowed charges *and* fewer than 100 unique Medicare patients per year. The proposed threshold, however, would help very few physicians and other clinicians. An AMA analysis of the 2014 "Medicare Provider Utilization and Payment Data: Physician and Other Supplier" file found that just 10% of physicians and 16% of all MIPS eligible clinicians would be exempt under the \$10,000/100 beneficiary proposal, and that these clinicians account for less than one percent of total Medicare allowed charges for Physician Fee Schedule services. As one example, by increasing the threshold to \$30,000 in Medicare allowed charges *or* fewer than 100 unique Medicare patients seen by the physician, CMS would provide a better safety net for small providers. This would exclude less than 30% of physicians while still subjecting more than 93% of allowed spending to MIPS. We recommend that the low-volume threshold be raised significantly in the final rule.

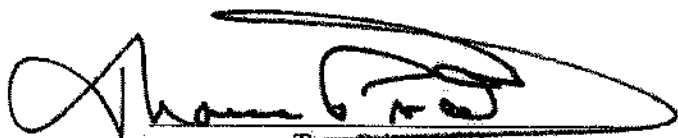
Resource Measures May Not Provide Accurate and Relevant Assessment of Physician Performance

³ CMS must minimize any unfair negative impact to small practices. In Table 64 of the proposed rule, CMS estimates that a disproportionate number of solo practitioners and small practices would fail the Merit-Based Incentive Program and would experience financial penalties as a result. CMS should modify its proposals to ensure an equal opportunity for all providers to succeed in the program.

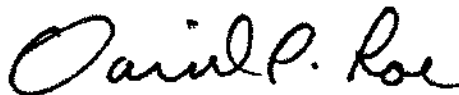
Resource use measures that CMS has used in the value-based modifier were originally developed for use in hospitals and are neither accurate nor relevant for many physicians. Recognizing this, Congress made clear that this category under MIPS should be limited to 10% *or less* of the total MIPS score in the first year and 15% *or less* in 2020. MACRA also called for the development of new episode measures and physician-patient relationship codes that are intended to improve the reliability and relevance of scores in this category. Final versions of the physician-patient relationship codes are not due to take effect until 2018 and many of the episode measures that CMS has developed to date have not been adequately reviewed by physicians or tested for use in physician offices. We believe that CMS should make the resource use category optional for at least one year while the measures and related methodologies are refined.

We strongly urge CMS to make necessary changes in the final rule so that physicians may be provided with the tools necessary to succeed under this new payment regime. We look forward to continuing to work with CMS to ensure effective implementation of this rule.

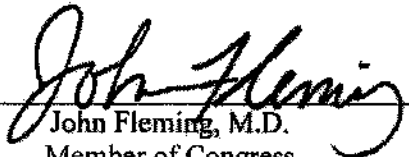
Sincerely,





Tom Price, M.D.
Member of Congress





David P. Roe, M.D.
Member of Congress


John Fleming, M.D.
Member of Congress


Andy Harris, M.D.
Member of Congress



Brad Wenstrup, D.P.M.
Member of Congress



Renee Ellmers, R.N.
Member of Congress



Diane Black, R.N.
Member of Congress


Larry Bucshon, M.D.
Member of Congress

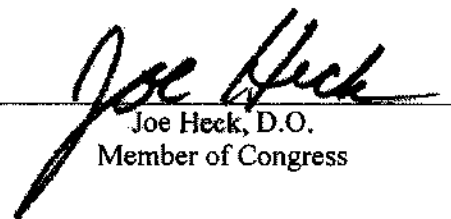

Dan Benishek, M.D.
Member of Congress

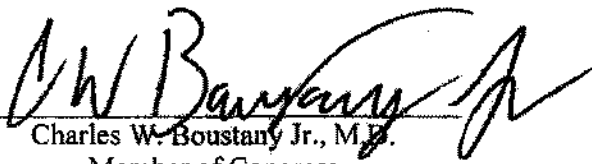

Paul A. Gosar, D.D.S.
Member of Congress

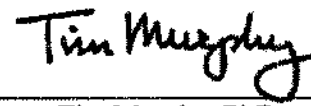

Earl L. "Buddy" Carter
Member of Congress

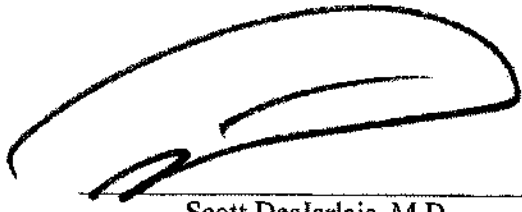

Ralph Abraham, M.D.
Member of Congress


Brian Babin, D.D.S.
Member of Congress

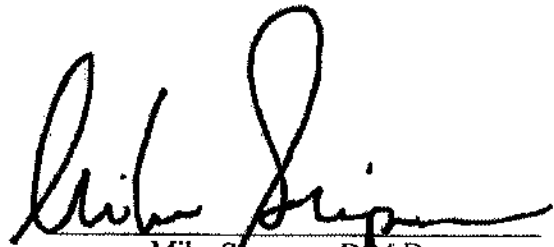

Joe Heck, D.O.
Member of Congress


Charles W. Boustany Jr., M.D.
Member of Congress


Tim Murphy, PhD
Member of Congress

A stylized, handwritten signature in black ink, consisting of a large, sweeping loop at the top and a few horizontal strokes below it.

Scott DesJarlais, M.D.
Member of Congress

A handwritten signature in black ink, written in a cursive style. The first name 'Mike' is clearly legible, followed by 'Simpson'.

Mike Simpson, D.M.D.
Member of Congress

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Thursday, October 20, 2016 8:18 PM
To: Chadwick, Alpheus K. (CMS/OL)
Cc: Martino, Maria (CMS/OL)
Subject: RE: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

No problem!

While CMS finds that compliance costs generally hover around \$1,200, the GAO in a report released last week highlighted that these costs are considerably higher. On p. 12 of the GAO report: While the study did not identify specifically how much of the cost of quality measurement is attributable to misalignment, the authors reported that physician practices spent 785.2 hours per physician per year on overall quality measurement efforts, *with an average annual cost of \$40,069 per physician.*

Thanks!!

From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Thursday, October 20, 2016 1:58 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: RE: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

Hello Carla – thx for taking time to speak with Maria and I yesterday about follow-up issues. During the conversation, you mentioned a GAO Report. Can you please send the link to that report? It would be very helpful for us to have the same context that you spoke of...thx.

-Al

From: DiBlasio, Carla [mailto:Carla.DiBlasio@mail.house.gov]
Sent: Wednesday, October 19, 2016 4:35 PM
To: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Cc: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Subject: Re: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

Just parked. I should be able to hop on the call in two minutes.

Thanks!

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

On Oct 19, 2016, at 4:31 PM, Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov> wrote:

No problem. If you want to try to talk tomorrow, we can do that too.

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Wednesday, October 19, 2016 4:30 PM
To: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: RE: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

Hello Carla – I think we will be able to wait for you, but please keep me posted...thx.

-Al

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Wednesday, October 19, 2016 4:27 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: Re: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

Al,

My sincere apologies but I'm stuck in traffic and my notes are sitting back in the office. I am running 5-10 min late.

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

On Oct 18, 2016, at 4:23 PM, Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov> wrote:

I've arranged a call-in number for tomorrow, Wednesday (10/19) at 4:30pm EST. To access the call, please dial 1-877-267-1577, and when prompted, Meeting Number: Thx.

-Al

From: Chadwick, Alpheus K. (CMS/OL)
Sent: Tuesday, October 18, 2016 4:12 PM
To: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: RE: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

Yes, 4:30pm should work on our end...thx.

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Tuesday, October 18, 2016 4:10 PM
To: Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>
Cc: Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: RE: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

No problem, AI.

Do you mind if we chat at 4:30 pm tomorrow? I don't think I'll be able to make 4 pm.

Thanks!

Carla

From: Chadwick, Alpheus K. (CMS/OL) [<mailto:Alpheus.Chadwick@cms.hhs.gov>]
Sent: Tuesday, October 18, 2016 3:09 PM
To: DiBlasio, Carla
Cc: Martino, Maria (CMS/OL)
Subject: FOLLOW-UP to Call with Dr. Price re: final MACRA rule

Hello Carla – are you available on Wednesday at 4pm to talk to Maria and I as a follow-up to Monday's call between Dr. Price and Patrick Conway?

-AI

From: Howell, Cherie A. (CMS/OL)
Sent: Friday, October 14, 2016 2:55 PM
To: Dugan, Meghan <Meghan.Dugan@mail.house.gov>
Cc: Puchalla (Creitz), Charlene <Charlene.Puchalla@mail.house.gov>; Price, Tom (DiBlasio, Carla) (<Carla.DiBlasio@mail.house.gov> <Carla.DiBlasio@mail.house.gov>); Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov>; Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>
Subject: RE: Call with Dr. Price re: final MACRA rule

Hello Meghan,

The call is scheduled for Monday, October 17, 2016 at 9:00 AM

Here is the conference call-in information.

Access Information

1. Please call the following number:
WebEx:
 2. Follow the instructions you hear on the phone.
- Your WebEx Meeting Number:

From: DiBlasio, Carla [<mailto:Carla.DiBlasio@mail.house.gov>]
Sent: Friday, October 14, 2016 10:33 AM
To: Howell, Cherie A. (CMS/OL) <Cherie.Howell@cms.hhs.gov>
Cc: Dugan, Meghan <Meghan.Dugan@mail.house.gov>; Puchalla (Creitz), Charlene <Charlene.Puchalla@mail.house.gov>
Subject: Call with Dr. Price re: final MACRA rule

Hey Cherie!

Thanks again for your call this AM. Dr. Price would like to speak with Patrick Conway on Monday afternoon regarding the final MACRA rule. I am looping in the Congressman's scheduling team to set something up. I believe you and AI have worked with our DC scheduler, Meghan Dugan, in the past.

Thanks so much!

Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
Washington, DC 20515 | 202.225.4501

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.DiBlasio@mail.house.gov>
Sent: Wednesday, November 2, 2016 5:12 PM
Subject: Re: Hill Notification: Medicare finalizes substantial improvements that focus on primary care, mental health, and diabetes prevention

Hey All

Sorry to miss your call. I just got out of a long meeting. I really appreciate the heads up.

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
Congressman Tom Price, M.D. (GA-06)
100 Cannon House Office Building
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On Nov 2, 2016, at 4:22 PM, Chadwick, Alpheus K. (CMS/OL) <Alpheus.Chadwick@cms.hhs.gov> wrote:

U.S. House and Senate Notification
Wednesday, November 2, 2016

To: Congressional Health Staff

From: Megan O'Reilly
Director, Office of Legislation
Centers for Medicare & Medicaid Services

Re: Medicare finalizes substantial improvements that focus on primary care, mental health, and diabetes prevention

Today, the Centers for Medicare & Medicaid Services (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. This is the first time a prevention model from the CMS Innovation Center will be adopted under the CMS authority to expand successful payment and service delivery models to reach all eligible beneficiaries.

The final rule updates payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule on or after January 1, 2017. Key policies finalized in the CY 2017 Physician Fee Schedule payment rule include:

Medicare Diabetes Prevention Program Expanded Model: CMS is finalizing its proposal to implement the Medicare Diabetes Prevention Program expanded model beginning January 1, 2018. CMS' finalized proposal would allow suppliers that have Centers for Disease Control and Prevention recognition to prepare to enroll in Medicare, and submit claims for furnish these services. CMS intends to finalize a process as soon as possible for these organizations to enroll

in Medicare so they can furnish services and begin billing by the time the expanded model becomes effective.

Primary Care and Care Coordination: The rule finalizes revisions to payment for chronic care management, including payment for new codes for complex chronic care management and for extra care management furnished by a physician or practitioner following the initiating visit for patients with multiple chronic conditions.

Mental and Behavioral Health: CMS is finalizing payments for codes that describe specific behavioral health services furnished using the psychiatric Collaborative Care Model, under which patients are cared for through a team approach involving a primary care practitioner, behavioral health care manager, and psychiatric consultant. CMS is also finalizing payment for a new code that broadly describes behavioral health integration services, including payments for other approaches and for practices that are not yet prepared to implement the Collaborative Care Mode.

Cognitive Impairment Care Assessment and Planning: CMS is finalizing payment to physicians to perform cognitive and functional assessment and care planning for patients with cognitive impairment (e.g., for patients with Alzheimer's).

CY 2017 Identification and Review of Potentially Misvalued Services: CMS is finalizing misvalued code changes that achieve 0.32 percent in net expenditure reductions. These changes do not fully meet the misvalued code target of 0.5 percent, thus requiring an adjustment to the 2017 overall physician update. After applying this and other adjustments required by law, the 2017 PFS conversion factor is \$35.89, an increase to the 2016 PFS conversion factor of \$35.80.

Collecting Data on Resources Used in Furnishing Global Services: CMS is finalizing a data collection strategy that significantly reduces the burden on practitioners compared to the proposed rule by: requiring reporting of post-operative visits only for high-volume/high-cost procedures; using existing CPT code 99024 instead of the proposed G-codes; requiring reporting only from a sample of practitioners consisting of those in larger practices (10 or more practitioners) in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island; and allowing all others to report voluntarily. In addition, while practitioners are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, the requirement to report will be effective for services related to global procedures furnished on or after July 1, 2017. To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.

In addition, CMS is finalizing changes to enhance program integrity and data transparency in Medicare Advantage. The rule also finalizes policies specific to certain sections of the Shared Savings Program regulations, including revisions that would permit eligible professionals in ACOs to report quality separately from the ACO.

The CY 2017 Medicare Physician Fee Schedule final rule is available at:
<https://www.federalregister.gov/public-inspection>.

A press release for the final rule is attached and will be available here:
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-11-02.html>. An overall fact sheet on this rule is attached and will be available here:
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets->

items/2016-11-02.html. A fact sheet about the MDPP expanded model is attached and will be available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-02-2.html>. A blog about the final rule will be available at: <http://blog.cms.gov/2016/11/02/a-healthier-medicare-focusing-on-primary-care-mental-health-and-diabetes-prevention>.

If you have any questions, please contact the Office of Legislation. Thank you.

<11-2-16 PFS Press Release FINAL.PDF>

<11-2-16 PFS Fact Sheet FINAL.PDF>

<11-2-16 MDPP fact sheet FINAL (004).pdf>

Chadwick, Alpheus K. (CMS/OL)

From: DiBlasio, Carla <Carla.Diblasio@mail.house.gov>
Sent: Thursday, December 8, 2016 12:30 PM
To: Chadwick, Alpheus K. (CMS/OL); Bill, Aaron
Martino, Maria (CMS/OL); Howell, Cherie A. (CMS/OL)
subject: RE: 2017 Quality Payment Program Self-Nomination Guide for Registries

Thanks for the heads up, Al!

I hope you are well!

Best,
Carla

Carla DiBlasio
Senior Policy Advisor/Legislative Counsel
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From: Chadwick, Alpheus K. (CMS/OL) [mailto:Alpheus.Chadwick@cms.hhs.gov]
Sent: Wednesday, December 07, 2016 4:21 PM
To: Bill, Aaron; DiBlasio, Carla
Cc: Martino, Maria (CMS/OL); Howell, Cherie A. (CMS/OL)
Subject: 2017 Quality Payment Program Self-Nomination Guide for Registries

ello Aaron and Carla ,

This is to let you know that the 2017 Quality Payment Program (QPP) Self-Nomination User Guide for vendors that want to participate as a Qualified Clinical Data Registry (QCDR) or Qualified Registry was posted on the CMS website today. This guide will help prospective vendors to understand how to self-nominate to participate in the program. It addresses the data needed to fully populate and submit a self-nomination, and also contains tips and visual aids to guide vendors through the self-nomination process.

For 2017, CMS requires prospective vendors to submit their complete self-nomination statement (including measures to be supported and the data validation plan) by January 15, 2017. The 2017 QPP Self-Nomination User Guide can be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2017-Quality-Payment-Program-Self-Nomination-User-Guide.pdf>

Let us know if you have any questions. Thank you.

-Al