

Thursday, August 4, 2016

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News & Announcements

Hospital IPPS and LTCH PPS Final Rule Policy and Payment Changes for FY 2017

On August 2, CMS issued a [final rule](#) to update FY 2017 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS). The final rule, which would apply to approximately 3,330 acute care hospitals and approximately 430 LTCHs, would affect discharges occurring on or after October 1, 2016.

The final increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful Electronic Health Record (EHR) users is approximately 0.95 percent. This reflects the projected hospital market basket update of 2.7 percent adjusted by -0.3 percentage point for multi-factor productivity and an additional adjustment of -0.75 percentage point in accordance with the Affordable Care Act. This also reflects a 1.5 percentage point reduction for documentation and coding required by the American Taxpayer Relief Act of 2012 and an increase of approximately 0.8 percentage points to remove the adjustment to offset the estimated costs of the Two Midnight policy and address its effects in FYs 2014, 2015, and 2016.

- In sum, CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about \$746 million in FY 2017
- This projected increase in spending includes an estimated \$350,000 increase in FY 2017 payments to hospitals located in Puerto Rico under the final policy to make IPPS payments for capital-related costs based solely on the national capital Federal rate

The final rule also includes:

- IPPS rate adjustments for documentation and coding and Two-Midnight Policy
- Medicare uncompensated care payments
- CMS-1632-F & IFC: Finalization of the extension of the Medicare-Dependent Hospital Program and low-volume hospital adjustment provided by MACRA
- Notification procedures for outpatients receiving observation services
- Hospital-Acquired Condition Reduction Program
- Hospital Readmissions Reduction Program
- Medicare and Medicaid EHR Incentive Programs
- Hospital IQR Program
- Hospital Value-Based Purchasing Program
- PPS-Exempt Cancer Hospital Quality Reporting Program
- Inpatient Psychiatric Facility Quality Reporting Quality Reporting Program
- LTCH PPS changes
- LTCH Quality Reporting Program

See the full text of this excerpted [CMS fact sheet](#) (issued August 2).

SNFs: Final FY 2017 Payment and Policy Changes

On July 29, CMS issued a final rule (CMS-1645-F) outlining FY 2017 Medicare payment policies and rates for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS), the SNF Quality Reporting Program (QRP), and the SNF Value-Based Purchasing (VBP) Program. CMS projects that aggregate payments to SNFs will increase in FY 2017 by \$920 million, or 2.4 percent, from payments in FY 2016. This estimated increase is attributable to a 2.7 percent market basket increase reduced by 0.3 percentage points, in accordance with the multifactor productivity adjustment required by law.

Changes to the SNF QRP:

- Adopts three measures to meet the resource use and other measure domains and one measure to satisfy the domain of medication reconciliation
- SNFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to the annual market basket percentage update factor for fiscal years beginning with FY 2018
- Policies and procedures associated with public reporting are being finalized, including the reporting timelines, preview period, review and correction of assessment-based and claims-based quality measure data, and the provision of confidential feedback reports to SNFs

SNF VBP Program:

- Specifies the SNF 30-Day Potentially Preventable Readmission Measure, (SNFPPR), as the all-cause, all-condition risk-adjusted potentially preventable hospital readmission measure as required by law
- Finalized additional policies, including establishing performance standards, establishing baseline and performance periods, adopting a performance scoring methodology, and providing confidential feedback reports to SNFs

For More Information:

- [Final Rule](#) will become effective on October 1, 2016
- [SNF PPS](#) website
- [SNF QRP](#) webpage
- [IMPACT Act Downloads and Videos](#) webpage
- [SNF VBP](#) webpage

See the full text of this excerpted [CMS fact sheet](#) (issued July 29).

Hospice Benefit: Final FY 2017 Payment and Policy Changes

On July 29, CMS issued a final rule (CMS-1652-F) outlining FY 2017 Medicare payment rates and wage index and the Hospice Quality Reporting Program (QRP) for hospices serving Medicare beneficiaries. As finalized, hospices would see a 2.1 percent (\$350 million) increase in their payments for FY 2017 (reflecting an estimated 2.7 percent inpatient hospital market basket update, reduced by a 0.3 percentage point productivity adjustment and a 0.3 percentage point adjustment required by law).

Changes to the Hospice QRP:

- Provides a description of the Hospice CAHPS® Survey and outlines participation requirements for the FY 2019 and FY 2020 annual payment updates
- Finalizes two new quality measures for FY 2017
- CMS expects to begin public reporting hospice quality measures via a Compare site in CY 2017

Enhanced Data Collection:

- CMS is considering enhancing the current Hospice Item Set (HIS) data collection instrument to be more in line with other post-acute care settings
- This revised data collection instrument would be a comprehensive patient assessment instrument, rather than the current chart abstraction tool

For More Information:

- [Final Rule](#) will become effective on October 1, 2016

- [Hospice Center](#) website

See the full text of this excerpted [CMS fact sheet](#) (issued July 29).

IRFs: Final FY 2017 Payment and Policy Changes

On July 29, CMS issued a final rule (CMS-1647-F) outlining FY 2017 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP). CMS is updating the IRF PPS payments for FY 2017 to reflect an estimated 1.65 percent increase factor (reflecting an IRF-specific market basket estimate of 2.7 percent, reduced by a 0.3 percentage point multi-factor productivity adjustment and a 0.75 percentage point reduction required by law). An additional approximate 0.3 percent increase to aggregate payments due to updating the outlier threshold results in an overall estimated update of approximately 1.9 percent (or \$145 million), relative to payments in FY 2016.

- No changes to the facility-level adjustment
- Rural adjustment transition: Continue year two of the phase-out of the 14.9 percent rural adjustment for IRF providers in areas that were designated as rural and changed to urban under the new Office of Management and Budget delineations

Changes to the IRF QRP:

- Adopts three measures to meet the resource use and other measure domains and one measure to satisfy the domain of medication reconciliation
- IRFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to their applicable FY annual increase factor
- Begin publically reporting IRF quality data in fall 2016
- Adopted an extension of the time frame for submission of exception and extension requests for extraordinary circumstances from 30 days to 90 days from the date of the qualifying event

For More Information:

- [Final Rule](#) will become effective on October 1, 2016
- [IRF PPS](#) website
- [IRF QRP](#) website

See the full text of this excerpted [CMS fact sheet](#) (issued July 29).

Inpatient Psychiatric Facilities: Final FY 2017 Payment and Policy Changes

On July 28, CMS issued a [notice](#) updating FY 2017 Medicare payment policies and rates for the Inpatient Psychiatric Facilities (IPFs) Prospective Payment System. CMS estimates IPF payments to increase by 2.2 percent or \$100 million in FY 2017. This amount reflects a 2.8 percent IPF market basket update less the productivity adjustment of 0.3 percentage point and less the 0.2 percentage point reduction required by law, for a net market basket update of 2.3 percent. Additionally, estimated payments to IPFs are reduced by 0.1 percentage point due to updating the outlier fixed-dollar loss threshold amount.

CMS is updating the IPF wage index for FY 2017. Wage index values will reflect the full adoption of the Office of Management and Budget area delineations finalized in the FY 2016 IPF PPS final rule, which provided a one-year transition during FY 2016.

See the full text of this excerpted [CMS fact sheet](#) (issued July 28).

CMS Announces Next Phase in Largest-ever Initiative to Improve Primary Care in America

On August 1, CMS opened the application period for practices to participate in the new nation-wide primary care model, Comprehensive Primary Care Plus (CPC+). CPC+ is a five-year primary care medical home model beginning January 2017 that will enable primary care practices to care for their patients the way they think will deliver the best outcomes and to pay them for achieving results and improving care. CPC+ is an opportunity for practices of diverse sizes, structures, and ownership who are interested in qualifying for the incentive payment for Advanced Alternative Payment Models through the proposed Quality Payment Program. CMS estimates that up to 5,000 primary care practices serving an estimated 3.5 million beneficiaries could participate in the model.

- Public-private partnership in 14 regions across the nation
- Multi-payer model: Medicare, state Medicaid agencies, and private insurance companies partner together to support primary care practices.

The following regions were selected for CPC+. Eligible practices in these 14 regions may apply between August 1 and September 15, 2016:

- Arkansas: Statewide
- Colorado: Statewide
- Hawaii: Statewide
- Kansas and Missouri: Greater Kansas City Region
- Michigan: Statewide
- Montana: Statewide
- New Jersey: Statewide
- New York: North Hudson-Capital Region
- Ohio: Statewide and Northern Kentucky Region
- Oklahoma: Statewide
- Oregon: Statewide
- Pennsylvania: Greater Philadelphia Region
- Rhode Island: Statewide
- Tennessee: Statewide

Practices may participate in one of two CPC+ tracks. In Track 1, CMS will pay practices a monthly fee in addition to regular Medicare Fee-For-Service (FFS) payments. In Track 2, practices will receive the monthly fee, as well as a hybrid of reduced Medicare FFS payments and up-front comprehensive primary care payments to allow greater flexibility in how practices deliver care. Practices in Track 2 will provide more comprehensive services for patients with complex medical and behavioral health needs. To promote high quality and high value care, practices in both tracks will also receive prospective performance-based incentive payments that they will either keep or have to pay back to CMS based on their performance on quality and utilization metrics. In addition, practices that participate in CPC+ may qualify for the additional incentive payments available for the Advanced Alternative Payment Models in the proposed Quality Payment Program beginning in 2019.

For questions about the model or the application process, visit the [CPC+](#) webpage or email CPCplus@cms.hhs.gov. See the full text of this excerpted [CMS press release](#) (issued August 1).

CMS Extends, Expands Fraud-Fighting Enrollment Moratoria Efforts in Six States

New Demonstration Enhances Agency's Enrollment and Investigative Options

On July 29, CMS announced an extension and statewide expansion of fraud-fighting temporary provider enrollment moratoria efforts in six states, along with a new related demonstration project to allow for certain exceptions to the moratoria and heightened screening requirements for new providers. CMS also announced it is immediately lifting the current temporary moratoria on all Medicare Part B, Medicaid, and Children's Health Insurance Program (CHIP) emergency ground ambulance suppliers.

CMS announced it is extending for six months and expanding statewide the temporary provider enrollment moratoria on new Medicare Part B non-emergency ground ambulance suppliers in New Jersey, Pennsylvania, and Texas and home health agencies in Florida, Texas, Illinois, and Michigan. Additionally, the statewide expansion also applies to Medicaid and CHIP. CMS also announced the Provider Enrollment Moratoria Access Waiver Demonstration (PEWD), which gives CMS the ability to allow for provider and supplier enrollment exceptions in the moratoria areas if access to care issues are identified and for the development and improvement of methods of investigating and prosecuting fraud in Medicare, Medicaid, and CHIP.

The statewide expansion of the temporary moratoria coupled with the PEWD will allow CMS to continue to target fraud within these services while granting individual enrollment waivers. These changes will address access to care issues and allow providers and suppliers who are subject to the moratoria to enroll in Medicare, Medicaid, and CHIP after passing heightened screening requirements. These changes are effective on July 29, 2016.

For more information, visit the [Transforming Clinical Practice Initiative](#) webpage. See the full text of this excerpted [CMS press release](#) (issued July 29).

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

On July 27, CMS updated the star ratings on the [Hospital Compare](#) website. The new Overall Hospital Quality Star Rating summarizes data from existing quality measures publicly reported on Hospital Compare into a single star rating for each hospital, making it easier for consumers to compare hospitals and interpret complex quality information. It will include 64 of the more than 100 measures displayed on Hospital Compare.

For More Information:

- [Overall Hospital Quality Star Rating Methodology Report](#), including a complete list of measures
- Blog: [Helping Consumers Make Care Choices through Hospital Compare](#)

See the full text of this excerpted [CMS fact sheet](#) (issued July 27).

Home Health Agencies: New PEPPER Available

A new Program for Evaluating Payment Patterns Electronic Report (PEPPER) for Home Health Agencies (HHAs) is available through the [PEPPER Resources Portal](#). CMS contracts with TMF to produce and distribute these free reports that summarize HHA claims data statistics for areas that may be at risk for improper Medicare payments. HHAs can use the data to support internal auditing and monitoring activities. Compare your Medicare billing practices with other HHAs in the nation, Medicare Administrative Contractor jurisdiction, and state. The report includes:

- Average case mix

- Average number of episodes
- Episodes with 5 or 6 visits
- Non- Low-Utilization Payment Adjustment (LUPA) payments
- High therapy utilization episodes
- Outlier payments

For More Information:

- PEPPERresources.org, including a sample HHA PEPPER
- [Distribution Schedule: How to Get Your PEPPER](#) webpage
- [HHA User Guide](#)
- Submit questions to the [Help Desk](#)

Partial Hospitalization Programs: New PEPPER Available

A new Program for Evaluating Payment Patterns Electronic Report (PEPPER) for Partial Hospitalization Programs (PHPs) is available. CMS contracts with TMF to produce and distribute these free reports that summarize PHP claims data statistics for areas that may be at risk for improper Medicare payments. PHPs can use the data to support internal auditing and monitoring activities. Compare your Medicare billing practices with other PHPs in the nation, Medicare Administrative Contractor jurisdiction, and state. Updated in this release:

- Target area for Days of Service with 4 Units Billed is discontinued
- New target area for Outlier Payments
- Summarizes the most recent three CYs (instead of FYs)
- Top Diagnosis report reflects the top 10 Clinical Classification System diagnoses (instead of the top 20 diagnosis codes)

Accessing your PEPPER:

- Free-standing PHPs access PEPPER through the [PEPPER Resources Portal](#)
- PHPs administered by short-term acute care hospitals or inpatient psychiatric facilities access PEPPER through the [QualityNet](#) secure portal

For More Information:

- PEPPERresources.org, including a sample PHP PEPPER
- [Distribution Schedule: How to Get Your PEPPER](#) webpage
- [PHP User Guide](#)
- Submit questions to the [Help Desk](#)

Physician Compare: 2014 Quality Data Available

Two new datasets are available through the [Physician Compare Downloadable Database](#):

- 2014 Physician Quality Report System (PQRS) clinical quality of care performance rates for six measures collected via claims for over 37,000 individual Eligible Professionals (EPs)
- 2014 PQRS Group Practice Reporting Option (GPRO) performance rates for 14 measures collected via Web Interface, as well as eight CAHPS for PQRS survey of patients' experiences summary survey measures for approximately 345 group practices

The database also includes demographic information and Medicare quality program participation for individual EPs, which is updated every two weeks. For questions, [Contact](#) the Physician Compare Support team.

Teaching Hospital Closures: Apply for Resident Slots by October 31, 2016

Section 5506 of the Affordable Care Act authorizes CMS to redistribute resident cap slots after a hospital that trained residents in an approved medical residency program(s) closes. On August 2, CMS announced Rounds 8, 9, and 10 in the Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System [final rule](#). The resident cap slots of the following closed hospitals will be redistributed:

- Round 8: Pacific Hospital of Long Beach, in Long Beach, CA (CCN 050277)
- Round 9: Huey P. Long Medical Center, in Pineville, LA (CCN 190009)
- Round 10: St. Joseph's Hospital, in Philadelphia, PA (CCN 390132)

First priority is given to hospitals in the same or contiguous core-based statistical areas as the closed hospitals. CMS must receive your hard copy applications for these resident cap slots by 5 pm ET on October 31, 2016. Visit the [Direct Graduate Medical Education](#) webpage for more information, including the [Section 5506 Application Form](#), [Guidelines for Submitting Application Forms Under Section 5506](#), and links to policy guidance.

PQRS: EIDM Accounts Required to Access Feedback Reports and 2015 Annual QRURs

CMS is releasing two reports in early fall that will require Enterprise Identity Management (EIDM) accounts to access:

- Physician Quality Reporting System (PQRS) feedback reports on your program year 2015 reporting results, including payment adjustment assessment for 2017
- 2015 Annual Quality and Resource Use Reports (QRURs) that will show how groups and solo practitioners performed in 2015 on the quality and cost measures used to calculate the 2017 Value Modifier

Prepare now by either signing up for an EIDM account or ensuring that your existing account is active. The same EIDM account can be used to access both reports. To register for an EIDM account, visit the [CMS Enterprise Portal](#). The [EIDM System Toolkit](#) has instructions for obtaining a new account, managing and updating information for an existing account, and adding account roles. For additional assistance, contact the QualityNet Help Desk at 866-288-8912 (TTY 877-715- 6222) or qnetsupport@hcqis.org.

Replacement of Accessories for Beneficiary-Owned CPAP Device or RAD

For information on the replacement of essential accessories used with a beneficiary-owned Continuous Positive Airway Pressure (CPAP) device or Respiratory Assist Device (RAD) purchased by Medicare following 13 months of continuous use, visit the [Durable Medical Equipment Center](#) website.

Administrative Simplification Statutes and Regulations

Did you know that Administrative Simplification is made up of statutes and regulations from both the [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) and the [Patient Protection and Affordable Care Act \(ACA\)](#)? Visit the newly enhanced [Statutes and Regulations](#) webpage:

- Key compliance dates
- Adopted standards
- Statutes and provisions
- [Timeline](#) showing the 20-year history of key Administrative Simplification laws and regulations

ICD-10 Coding Resources

The [ICD-10](#) website features official coding resources that can help you maintain your ICD-10 progress, including:

- 2017 [ICD-10-CM](#) diagnosis and [ICD-10-PCS](#) inpatient procedure code sets and guidelines
- [Specialty Resources Guide](#)
- [Quick Start Guide](#)
- Clinical Concepts Series: [Family Practice](#), [Internal Medicine](#), [Cardiology](#), [OB/GYN](#), [Orthopedics](#), and [Pediatrics](#)
- MLN Connects® Videos: [ICD-10 Coding Basics](#), [Coding for ICD-10-CM: More of the Basics](#)
- [ICD-10 Post-Implementation: Coding Basics Revisited](#)

Visit the [ICD-10](#) website and [Roadto10.org](#) for the latest news and official resources, including the [Next Steps Toolkit](#) and a [contact list for provider Medicare and Medicaid questions](#).

Vaccines are Not Just for Kids

National Immunization Awareness Month (NIAM) is an annual observance held in August to highlight the importance of vaccination. All adults should get vaccines to protect their health. Even healthy adults can become seriously ill, and can pass certain illnesses on to others. Talk to your Medicare patients about vaccines they may need.

For More Information:

- [Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Educational Tool](#)
- [Mass Immunizers and Roster Billing: Simplified Billing for Influenza Virus and Pneumococcal Vaccinations](#) Fact Sheet
- [Vaccine and Vaccine Administration Payments Under Medicare Part D](#) Fact Sheet
- [Medicare Preventive Services](#) Educational Tool
- Centers for Disease Control and Prevention [NIAM](#) website
- [NIAM](#) Toolkit

Visit the [Preventive Services](#) website to learn more about Medicare-covered services.

Provider Compliance

Hospital Discharge Day Management Services

Avoid delays. Bill it right the first time. The [CMS Provider Minute: Hospital Discharge Day Management Services](#) video includes helpful pointers to properly bill for these services. Learn about:

- Appropriate Healthcare Common Procedure Coding System (HCPCS) codes
- Who can submit a bill

This video is part of a [series](#) to help providers of all types improve in areas identified with a high degree of noncompliance.

Upcoming Events

PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10

Wednesday, August 10 from 1:30 to 3 pm ET

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

Learn about Physician Quality Reporting System (PQRS) negative payment adjustments, feedback reports, and the informal review process for program year 2015 results and 2017 payment adjustment determination.

Agenda:

- PQRS negative payment adjustment, feedback reports, and informal review
- How to request an informal review
- Where to call for help and resources
- Question and answer session

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

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

Data Collection on Resources Used in Furnishing Global Services Information Session — August 11

Thursday, August 11 from 2 to 3 pm ET

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

During this call, learn about the proposed data collection activities on resources used in furnishing global services outlined in the CY 2017 Physician Fee Schedule Proposed Rule ([CMS-1654-P](#)). Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 ([MACRA](#)) requires CMS to develop and implement a process to gather and analyze the necessary data on pre- and post-operative visits and other services furnished during global surgical periods other than the surgical procedure itself. This call will not include a question and answer session.

Agenda:

- Background on Medicare payments for global surgical packages
- Physician Fee Schedule proposal and MACRA Section 523 requirement for CMS to collect data to value surgical services
- Proposed approach for data collection

Target Audience: Practitioners who furnish surgical services to Medicare beneficiaries; state and national associations that represent these practitioners; integrated delivery systems representatives; coding professionals; and practice managers.

IMPACT Act: Data Elements and Measure Development Call — August 31

Wednesday, August 31 from 1:30 to 3

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

During this call, CMS experts discuss how data elements are used in measure development. Find out how information from assessment instruments is used to calculate quality measures. The Improving Medicare Post-Acute Care Transformation Act of 2014 ([IMPACT Act](#)) requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Agenda:

- Overview of National Quality Strategy and CMS Quality Strategy
- Why do we have quality measures?
- How do data elements fit within measure development?
- How is provider data used in the development process?
- Example: pressure ulcer measure
- Question and answer/discussion session

Target Audience: PAC providers, healthcare industry professionals, clinicians, researchers, health IT vendors, and other interested stakeholders.

National Partnership to Improve Dementia Care and QAPI Call — September 15

Thursday, September 15 from 1:30 to 3 pm ET

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

This call focuses on effective care transitions between long-term and acute care settings, highlighting transitions that involve residents with dementia. This is critical for residents with dementia, as care transitions can cause heightened anxiety and aggression. Communication should be optimized, as care transitions are high-risk periods for nursing home residents. Additionally, CMS subject matter experts share updates on the progress of the [National Partnership to Improve Dementia Care in Nursing Homes](#) and [Quality Assurance and Performance Improvement](#) (QAPI). A question and answer session will follow the presentations.

Speakers:

- Dr. Kevin Biese, University of North Carolina (UNC), Department of Emergency Medicine

- Tammie Stanton, UNC Health Care System
- Kathryn Weigel, Rex Rehabilitation & Nursing Care Center of Apex
- Scott Bartlett, Pikes Peak Area Council of Governments – Area Agency on Aging
- Michele Laughman and Debbie Lyons, CMS

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

Medicare Learning Network® Publications & Multimedia

Remittance Advice Information: An Overview Fact Sheet — Reminder

A revised [Remittance Advice Information: An Overview](#) Fact Sheet is available. Learn about:

- What types of Remittance Advice (RA) are available
- What information is included in an RA
- How to view an RA

Medicare Costs at a Glance: 2016 Educational Tool — Revised

A revised [Medicare Costs at a Glance: 2016](#) Educational Tool is available. To order a hard copy, visit the [Learning Management and Product Ordering System](#). Learn about the costs beneficiaries pay for Medicare Parts A, B, C, and D in 2016.

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