News & Announcements

First CMS Rural Health Strategy
On May 8, CMS released its first Rural Health Strategy intended to provide a proactive approach on healthcare issues to ensure that the nearly one in five individuals who live in rural America have access to high quality, affordable healthcare. “For the first time, CMS is organizing and focusing our efforts to apply a rural lens to the vision and work of the agency,” said CMS Administrator Seema Verma. “The Rural Health Strategy supports CMS’ goal of putting patients first. Through its implementation and our continued stakeholder engagement, this strategy will enhance the positive impacts CMS policies have on beneficiaries who live in rural areas.”

The agency-wide Rural Health Strategy, built on input from rural providers and beneficiaries, focuses on five objectives to achieve the agency’s vision for rural health:

- Apply a rural lens to CMS programs and policies
- Improve access to care through provider engagement and support
- Advance telehealth and telemedicine
- Empower patients in rural communities to make decisions about their healthcare
- Leverage partnerships to achieve the goals of the CMS Rural Health Strategy
**Direct Provider Contracting RFI — Submit Comments by May 25**

CMS announced a Request for Information (RFI) on Direct Provider Contracting (DPC) models, contracting between payers and primary care or multi-specialty practices within the Medicare fee-for-service, Medicare Advantage, and Medicaid programs. We would like your input on testing and design features of a potential model, including:

- Provider/state participation
- Beneficiary participation
- Payment
- General model design
- Program integrity and beneficiary protections
- Existing CMS initiatives

For More Information:
- DPC Models – RFI webpage
- Submit your comments and questions to DPC@cms.hhs.gov by 11:59 pm ET on May 25

**Provider Documentation Manual: Home Use of Oxygen — Submit Comments on Draft by May 31**

CMS will create a new Internet Only Manual – the Provider Documentation Manual, which will list all required documentation for Medicare payment. We welcome feedback on the first draft section: Home Oxygen Therapy:

- Submit comments to ProviderDocumentationManual@cms.hhs.gov by May 31
- Attend a Special Open Door Forum on Thursday, May 10 at 2 pm
- Visit the Reducing Provider Burden webpage for more information

**Hospital Compare Preview Reports Available through June 2**

July 2018 Hospital Compare Preview Reports are available through the QualityNet Secure Portal through June 2. Participating hospitals: access and download your reports early in the preview period to conduct a thorough review; these reports are only available during the preview period. The data in the Preview Reports will be reported in July 2018 on the Hospital Compare website.

**eCQM Annual Update**

CMS posted the electronic Clinical Quality Measure (eCQM) annual update for:

- Eligible hospitals and critical access hospitals
- Eligible professionals and eligible clinicians

For More Information:
- eCQI Resource Center website
- Guide to Reading eCQMs
- Value Set Authority Center website
- Visit the eCQM Issue Tracker to provide feedback; an ONC Issue Tracking System account is required
CMS published the 2019 CMS Quality Reporting Document Architecture (QRDA) Category I Hospital Quality Reporting Implementation Guide, Schematron, and sample files. The Implementation Guide provides technical instructions for reporting electronic clinical quality measures for the CY 2019 reporting period for the following programs:

- Hospital Inpatient Quality Reporting Program
- Medicare and Medicaid Promoting Interoperability Programs for eligible hospitals and critical access hospitals

For More Information:
- eCQI Resource Center QRDA webpage
- For questions, visit the ONC QRDA JIRA Issue Tracker.

2018 Measure Development Plan Annual Report

CMS posted the 2018 Quality Measure Development Plan Annual Report, which describes progress in developing clinician quality measures to support the Quality Payment Program. For more information about the report, visit the Measure Development webpage.

National Women’s Health Week Kicks off on Mother’s Day

National Women’s Health Week, May 13 through 19, empowers women to make their health a priority. Encourage your Medicare patients to take steps to improve their health and recommend appropriate preventive services.

For More Information:
- Medicare Preventive Services Educational Tool
- National Women’s Health Week webpage
- Centers for Disease Control and Prevention Women’s Health website

Visit the Preventive Services website to learn more about Medicare-covered services.

Provider Compliance

Reporting Changes in Ownership — Reminder

A 2016 Office of the Inspector General (OIG) report noted that providers may not be informing CMS of ownership changes. Providers must update their enrollment information to reflect changes in ownership within 30 days. Owners are individuals or corporations with a 5 percent or more ownership or controlling interest. Failure to comply could result in revocation of your Medicare billing privileges.

Resources:
- Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure OIG Report, May 2016
- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article
- Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article
- 42 CFR 424.516
- PECOS Enrollment Tutorial - Change of Information for an Individual Provider
- PECOS Enrollment Tutorial - Change of Information for an Organization/Supplier
Upcoming Events

Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
Wednesday, May 16 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, CMS answers frequently asked questions about the Quality Payment Program from the 2018 Healthcare Information and Management Systems Society (HIMSS18) Annual Conference & Exhibition and inquiries received by the Quality Payment Program Service Center. Then, we open the phone lines to take your questions.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:

- The Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

Target Audience: Medicare Part B fee-for-service clinicians; office managers and administrators; state and national associations that represent healthcare providers; and other stakeholders.

Managing Older Adults with Substance Use Disorders Webinar — May 16
Wednesday, May 16 from 12 to 1:30 pm ET

Register for this webinar.

Part of the Geriatric Competent Care series, this webinar describes Substance Use Disorder (SUD), how to diagnose SUD, and available treatment resources. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

FY 2019 IPPS Proposed Rule: eCQM Reporting Webinar — May 16
Wednesday, May 16 from 2 to 3 pm ET

Register for this webinar.

This presentation provides an overview of the proposals in the recently released FY 2019 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital PPS proposed rule related to electronic Clinical Quality Measure (eCQM) reporting requirements for the Hospital Inpatient Quality Reporting Program and the Promoting Interoperability Programs.

Settlement Conference Facilitation Expansion Call — May 22
An Alternative Dispute Resolution Initiative
Tuesday, May 22 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

As part of the broader commitment by HHS to improving the Medicare claims appeals process, the Office of Medicare Hearings and Appeals (OMHA) is expanding the current Settlement Conference Facilitation (SCF) program to reach additional providers and suppliers. SCF is an alternative dispute resolution process that gives certain providers and suppliers an opportunity to resolve their eligible Part A and Part B appeals pending at OMHA and the Medicare Appeals Council (Council).
During this call, learn about the newly expanded SCF Initiative, which appeals are eligible for SCF, and the SCF process. Visit the [OMHA SCF](https://www.oma.gov/scf/) website for more information.

A question and answer session follows the presentation; however, attendees may email questions in advance to [OMHA.SCF@hhs.gov](mailto:OMHA.SCF@hhs.gov) with “SCF May 22 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

Target Audience: Medicare Part A and Part B providers and suppliers with a total of 500 or more appeals pending at OMHA and the Council combined; or Medicare Part A and Part B providers and suppliers with any number of appeals pending at OMHA and the Council that each have more than $9,000 in billed charges.

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**Qualified Medicare Beneficiary Program Billing Requirements Call — June 6**

Wednesday, June 6 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, CMS experts discuss the Qualified Medicare Beneficiary (QMB) billing requirements and their implications. Find out about the July 2018 re-launch of changes to the remittance advice and November 2017 changes to the HIPAA Eligibility Transaction System (HETS) to identify the QMB status of your patients and exemption from cost-sharing. Also, learn key steps to promote compliance.

Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays. Visit the [QMB Program](https://www.oma.gov/qmb-program/) webpage for more information.

Target Audience: Medicare Part A and B providers, medical billing specialists, practice administrators, IT vendors, health care industry professionals, and other interested stakeholders.

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**Medicare Learning Network® Publications & Multimedia**

**Inexpensive or Routinely Purchased DME Payment Classification for SGD and Accessories MLN Matters Article — New**

A new MLN Matters Article on Inexpensive or Routinely Purchased Durable Medical Equipment (DME) Payment Classification for Speech Generating Devices (SGD) and Accessories is available. Use of these items continue to be classified under the inexpensive or routinely purchased DME payment category.

**Medicare Cost Report E-Filing MLN Matters Article — New**

A new MLN Matters Article on Medicare Cost Report E-Filing (MCReF) is available. Learn about streamlining of the MCR filing process.

**MCReF System Webcast: Audio Recording and Transcript — New**

An audio recording and transcript are available for the May 1 webcast on the Medicare Cost Report e-Filing (MCReF) system. Medicare Part A providers, starting July 2, you must use MCReF if you choose electronic submission of your cost report.

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Like the newsletter? Have suggestions? Please let us know!