# CMS Region 7 Updates

05/21/2017

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# *ACA/Marketplace Updates*

## Centers for Medicare and Medicaid Services Offers New Health Coverage Enrollment Option for Small Business

The Centers for Medicare & Medicaid Services (CMS) announced a plan to change the way that small businesses enroll in insurance coverage through the Federal exchanges, offering employers the help they need to find affordable insurance for their employees.

The Federally-Facilitated Small Business Health Options Program (FF-SHOP) program was mandated under the Affordable Care Act (ACA), but failed to sign-up significant numbers of small employers. Out of the nearly 30 million small businesses in the country, less than 8,000, just .1 percent of small businesses currently participate in the FF-SHOPs in 33 states, which cover less than 40,000 individuals nationwide. SHOP programs are now defunct and do not provide needed insurance coverage for small businesses.

"Our goal is to reduce ACA burdens on consumers and small businesses and make it easier for them to purchase coverage," said CMS Administrator Seema Verma. "The ACA has failed to provide affordable insurance to small business and to the American people. This new direction will help employers find affordable healthcare coverage for their employees and make the SHOP exchanges function more effectively."

As part of the changes CMS intends to propose, employers would still obtain a determination of SHOP eligibility through HealthCare.gov. The move would reduce the federal government's role in healthcare coverage decisions and make it easier for issuers to use their own enrollment systems for SHOP plans. Online enrollment would be removed from HealthCare.gov and small employers would access coverage through an agent or broker, or an issuer of their choice, for plan years beginning on or after January 1, 2018.

The FF-SHOPs exist in states where the SHOP program is operated by the federal government. Small businesses with SHOP coverage that took effect in 2017 would be able to continue using HealthCare.gov for enrollment and premium payment until their current plan year ends. Some employers that purchase SHOP coverage are also able to access the Small Business Health Care Tax Credit. This option will still be available to small employers who purchase coverage under the new enrollment approach.

Under the intended approach, state-based SHOPs not using HealthCare.gov could continue to operate as they have previously.

For more information please click here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/The-Future-of-the-SHOP-CMS-Intends-to-Allow-Small-Businesses-in-SHOPs-Using-HealthCaregov-More-Flexibility-when-Enrolling-in-Healthcare-Coverage.pdf

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## 2017 CMS Assister Summit: Understanding the Evolving Marketplace

Registration is now open for the 2017 CMS Assister Summit!

CMS will host a two-day Marketplace assisters training in Baltimore Maryland and via webcast on June 28 & 29, 2017. This interactive event will include in-depth assister training and education on a variety of topics that support Marketplace program integrity and stability.

All assisters are invited to attend via webcast. Assister organizations attending via webcast are encouraged to host watch parties during the two-day event.

**Join us for Two Days of Marketplace Assister Training**:

June 28, 2017 (12PM - 5PM EDT)

Day 1 will focus on The Future Role of Assisters

June 29, 2017 (9AM - 5PM EDT)

Day 2 will focus on Optimizing Consumer Experience

**Webcast Registration:** Click here to register to attend the 2017 CMS Assister Summit via webcast. Participants who register in advance will receive a confirmation email with additional event details.

Due to building capacity, a limited number of FFM assisters are invited to attend in-person. Please check with your organization's Assister Program Management for information regarding in-person attendance.


# Thank you for joining us for the 2017 CMS Assister Summit!

## *Understanding the Evolving Marketplace*

**Day 1** will focus on The Future Role of Assisters

**Day 2** will focus on Optimizing Consumer Experience

**Below are three distinct learning tracks, please use the key to determine which sessions you would like to attend, if you are participating in person.**

**Please note: only sessions in the Grand Auditorium will be webcast.**

### Color Code Key of Learning Tracks

**= Stabilize the Risk Pool through Outreach and Enrollment**

This track focuses on developing best practices for how to work with, educate, and enroll consumers and reach target populations.

**= How to Run an Accountability Centered Assister Program**

This track focuses on the key tools and skills that have been demonstrated to be most effective in building professional and exceptional assister programs.

**= Deep Dive on Marketplace Policy and Programs/How to Handle Complex Issues**

This track focuses on providing information and tips for resolving complex and challenging concepts that assisters routinely encounter.


| | | | |
|---|---|---|---|
| 12:00 pm - 12:30 pm | **CHECK-IN & BADGING** | | |
| 12:30 pm - 12:50 pm *(Grand Auditorium Plenary)* | **WELCOME & DAY 1 OVERVIEW** | | |
| 12:50 pm - 1:20 pm *(Grand Auditorium Plenary)* | **VISION FOR ASSISTERS IN THE EVOLVING MARKETPLACE** | | |
| | **Grand Auditorium** | **C-110** | **C-112** |
| 1:30 pm - 2:30 pm *(Concurrent Sessions)* | **Data-driven Outreach: Reaching Target Populations** | **Assister Best Practices on Collaborations** | **Enrollment Troubleshooting** |
| 2:30 pm - 2:45 pm | **AFTERNOON BREAK** | | |
| | **Grand Auditorium** | **C-112** | **C-110** |
| 2:45 pm - 3:45 pm *(Concurrent Sessions)* | **From Coverage to Care** | **HIOS Metric Reporting Strategies** | **Marketplace Appeals** |
| 3:55 pm - 5:00 pm *(Assister Specific Concurrent Sessions)* | **Grand Auditorium** | **C-110 & C-111 & C-112** | |
| | **Certified Application Counselor Update Session** | **Navigator Update Session** | |

**TRACK KEY:**

= Stabilize the Risk Pool through Outreach and Enrollment

= How to Run an Accountability Centered Assister Program

= Deep Dive on Marketplace Policy and Programs/ How to Handle Complex Issues


| | | | |
|---|---|---|---|
| 8:30 am - 9:00 am | **CHECK-IN & BADGING** | | |
| 9:00 am - 9:15 am *(Grand Auditorium)* | **WELCOME & DAY 2 OVERVIEW** | | |
| 9:15 am - 10:15 am *(Grand Auditorium)* | **KEEPING CONSUMERS COVERED** | | |
| 10:15 am - 10:30 am | **MORNING BREAK** | | |
| 10:30 am - 11:30 am *(Concurrent Sessions)* | **Grand Auditorium** | **C-111** | **C-112** |
| | **Overlapping Coverage: Medicaid & the Marketplace** | **Creating Successful Outreach & Education Events** | **Market Stabilization Final Rule Overview** |
| 11:40 am - 12:40 pm *(Concurrent Sessions)* | **Grand Auditorium** | **C-111** | **C-112** |
| | **Overlapping Coverage: Medicare Transitions** | **Assister Best Practices on Post-enrollment Assistance** | **Balancing the Risk Pool: Enrolling New Americans & New Arrivals** |
| 12:40 pm - 1:50 pm | **LUNCH BREAK** | | |
| 1:00 pm - 1:40 pm *(Working Lunch Sessions)* | **C-110** | **C-111** | **C-112** |
| | **Working Lunch - Assister Brainstorming** on Savvy Social Media Use, Outreach to Vulnerable Populations & Working with Corrections Systems/Courts | **Working Lunch - Assister Brainstorming** on Innovative Ways to Reach Millennials, Connecting Kids to Coverage & Working with Separating Military | **Working Lunch - Assister Brainstorming** on Helping Consumers Understand Plan Options, Marketing and Promotion & Working with Medical Providers |
| 1:50 pm - 2:50 pm *(Concurrent Sessions)* | **Grand Auditorium** | **C-112** | **C-111** |
| | **Special Enrollment Periods Overview** | **Assister Mentoring Project** | **Balancing the Risk Pool: Enrolling Young Adults & Other Hard-to-Reach Populations** |
| 3:00 pm - 4:00 pm *(Concurrent Sessions)* | **Grand Auditorium** | **C-111** | **C-112** |
| | **Special Enrollment Periods Verification** | **Building Robust Organizations: Best Practices for Hiring, Retention & Managing Subgrantees** | **Helping Consumers With Employment Related Coverage Issues** |
| 4:00 pm - 4:15 pm | **AFTERNOON BREAK** | | |
| 4:15 pm - 5:00 pm *(Grand Auditorium)* | **Assister Town Hall & Closing Remarks** | | |

**TRACK KEY:**

- = Stabilize the Risk Pool through Outreach and Enrollment
- = How to Run an Accountability Centered Assister Program
- = Deep Dive on Marketplace Policy and Programs/ How to Handle Complex Issues

We Support GO GREEN


**Learning Track Guide**

*Use the key below to determine which concurrent sessions you would like to attend, if you are participating in person. Please note: only sessions in the Grand Auditorium will be webcast for viewing by remote participants, these sessions are listed in* ***bold****.*

## = Stabilize the Risk Pool through Outreach and Enrollment

This track focuses on developing best practices for how to work with, educate, and enroll consumers and reach target populations.

| Session Title | Date & Time |
|---|---|
| **Data-driven Outreach: Reaching Target Populations** | ***Wednesday, 1:30 pm - 2:30 pm EST*** |
| **From Coverage to Care** | ***Wednesday, 2:45 pm - 3:45 pm EST*** |
| Market Stabilization Final Rule Overview | *Thursday, 10:30 am - 11:30 am EST* |
| Balancing the Risk Pool: Enrolling New Americans & New Arrivals | *Thursday, 11:40 am - 12:40 pm EST* |
| Balancing the Risk Pool: Enrolling Young Adults & Other Hard-to-Reach Populations | *Thursday, 1:50 pm - 2:50 pm EST* |
| Helping Consumers with Employment Related Coverage Issues | *Thursday, 3:00 pm - 4:00 pm EST* |

## = How to Run an Accountability Centered Assister Program

This track focuses on the key tools and skills that have been demonstrated to be most effective in building professional and exceptional assister programs.

| Session Title | Date & Time |
|---|---|
| Assister Best Practices on Collaborations | *Wednesday, 1:30 pm - 2:30 pm EST* |
| HIOS Metric Reporting Strategies | *Wednesday, 2:45 pm - 3:45 pm EST* |
| Creating Successful Outreach & Education Events | *Thursday, 10:30 am - 11:30 am EST* |
| Assister Best Practices on Post-enrollment Assistance | *Thursday, 11:40 am - 12:40 pm EST* |
| Assister Mentoring Project | *Thursday, 1:50 pm - 2:50 pm EST* |
| Building Robust Organizations: Best Practices for Hiring, Retention, & Managing Subgrantees | *Thursday, 3:00 pm - 4:00 pm EST* |

## = Deep Dive on Marketplace Policy and Programs/ How to Handle Complex Issues

This track focuses on providing information and tips for resolving complex and challenging concepts that assisters routinely encounter.

| Session Title | Date & Time |
|---|---|
| Enrollment Troubleshooting | *Wednesday, 1:30 pm - 2:30 pm EST* |
| Marketplace Appeals | *Wednesday, 2:45 pm - 3:45 pm EST* |
| **Overlapping Coverage: Medicaid & the Marketplace** | ***Thursday, 10:30 am - 11:30 am EST*** |
| **Overlapping Coverage: Medicare Transitions** | ***Thursday, 11:40 am - 12:40 pm EST*** |
| **Special Enrollment Periods (SEP) Overview** | ***Thursday, 1:50 pm - 2:50 pm EST*** |
| **Special Enrollment Periods (SEP) Verification** | ***Thursday, 3:00 pm - 4:00 pm EST*** |

## Checklist for Section 1332 State Innovation Waiver Applications, including specific items applicable to High-Risk Pool/State-Operated Reinsurance Program Applications

Checklist Aims to Help Stabilize State Health Insurance Markets for 2018

**WASHINGTON, DC, May 16, 2017;** - Today, the Centers for Medicare and Medicaid Services (CMS) released new information to help states seek waivers from requirements in the Affordable Care Act (ACA). The new tool is intended to help states complete waiver applications that allow them to establish high-risk pools/ state-operated reinsurance programs. Section 1332 waivers, generally can be used by states to opt-out of some mandated provisions under ACA.

CMS is helping to provide guidance to states who want to pursue solutions to help lower costs and increase coverage choices for Americans struggling with unaffordable premiums and reduced competition in the insurance market, brought on by the ACA. Individuals obtaining coverage in the ACA marketplace have faced double-digit premium increases and insurance issuer exits.

Nationally, premiums on Healthcare.gov have increased by an average of 25 percent for 2017. The state of Arizona saw insurance costs go up more than 100 percent and one third of counties in the U.S. currently only have one insurer participating in the exchange. Two insurance carriers in Iowa recently announced they were exiting the market, leaving Iowans in jeopardy of having no insurers participating in the exchange in 2018.

"Today's guidance addresses the ACA's impact in driving up insurance costs and reducing choices," said CMS Administrator Seema Verma. "State initiated waivers that implement high-risk pool/ state-operated reinsurance programs will help lower premiums, stabilize the health insurance exchange, and meet the unique needs of each state."

States have unique sets of challenges within the health insurance exchange and in the broader individual health insurance market. In Alaska, for example, initial rate information showed the state could face a potential 40 percent increase in premiums in the 2017 plan year. In an effort to stabilize premiums, the state introduced a reinsurance program to offset the projected increase. The move helped to steady premiums, and Alaska is now requesting a 1332 State Innovation Waiver in order to continue the program for future plan years. If approved, the state could receive federal funding to offset a portion of the costs. Federal law requires the 1332 reinsurance program to be budget neutral, so it will not increase costs for taxpayers.

U.S. Health and Human Services (HHS) Secretary Thomas E. Price sent a letter to all states encouraging them to use innovative strategies to strengthen their health insurance markets. For more information on 1332 State Innovation Waivers, see the March 2017 letter from Secretary Price. More information on section 1332 State Innovation Waivers is also available here.

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## Proxy Direct Enrollment Pathway for 2018 Individual Market Open Enrollment Period

The direct enrollment (DE) pathway – the functionality that allows a consumer or an issuer, agent or broker assisting a consumer to shop for coverage on a third party website, is an important method to encourage innovative ways to provide an improved customer experience and easier access to enroll in individual market Exchange coverage offered through HealthCare.gov. In order to reduce undue regulatory burden on DE entities, and in the interest of expanding direct enrollment for Open Enrollment 5 for plan year 2018, CMS will no longer require the consumer-facing redirect with Security Assertion Markup Language (SAML)2 for all individual market enrollment transactions for coverage offered through the Federally-facilitated Exchanges (FFEs) and State-Based Exchanges on the Federal Platform (SBE-FPs) that rely on HealthCare.gov for individual market eligibility and enrollment functions, and will permit DE entities to use a "proxy direct enrollment" pathway, under which DE entities may collect consumer information on its website and input that information into HealthCare.gov.
This approach is intended to provide consumers with access to new and innovative shopping experiences for individual market coverage offered through the FFEs and SBE-FPs and further stabilize the risk pool by providing more ways for consumers to access coverage. To minimize risk to HealthCare.gov functionality and of eligibility inaccuracies,

CMS will restrict use of proxy direct enrollment as follows:

- All proxy direct enrollments will occur secured with CMS-issued credentials issued to individuals responsible for proxy direct enrollment. Consistent with existing procedures, DE entities may not create Exchange accounts on behalf of individual consumers.

Proxy direct enrollment will be limited to simple cases currently served by Application 2.0Complex enrollments, SEPs, and terminations will not be supported. In accordance with 45 C.F.R. § 155.220(c)(1) and 45 C.F.R. § 155.405, the screener questions, application language and application flow will be provided to DE entities by CMS and must be duplicated exactly on the DE entities website for all "proxy direct enrollments". For those consumers not supported by Application 2.0, DE entities must support these individuals through the current double redirect process in the existing direct enrollment pathway consistent with 45 C.F.R. § 155.220(c)(3)(i) or direct them to HealthCare.gov to complete the application and receive an eligibility determination.

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1 Health Insurance ExchangeSM and ExchangeSM are service marks of the U.S. Department of Health & Human Services.
2 Role of Agents, Brokers, and Web-brokers in Health Insurance Marketplaces (November 7, 2014 Update), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-_Marketplaces/Downloads/May_1_2013_CCIIO_AB_-Guidance_110414_508.pdf.

o To limit burden on issuers to manage re-enrollment for individuals who had previously come to the Exchange for coverage and to avoid duplicate enrollments, DE entities must use existing search functionality where feasible to determine whether an existing application/enrollment is present for a given consumer and use the current application/enrollment to allow the consumer to apply for and select a new plan for the next open enrollment.

- CMS will not allow retries or bulk submissions due to potential for proxy direct enrollment to degrade Exchange systems and hamper the experience for all users.
- CMS may require DE entities to notify consumers of data matching issues (DMIs), pre- enrollment SEP verification status, and clearly outline tax liability implications of APTC, including next steps for the consumer to submit documents and pay premiums.
- DE entities must attest via an agreement with CMS that the entity will comply with the restrictions stated above.
- CMS may release future guidance on privacy and security requirements for DE Entities using the proxy method for enrollments to ensure that this pathway is in compliance with Federal privacy and security standards.

In addition to these requirements, DE entities must implement a FICAM TFS approved identity service provider for consumers.

Entities wishing to participate in proxy direct enrollment will retain a third party auditor that meets CMS's approval to validate compliance with the restrictions outlined above, as well as with the privacy and security standards. Third party audits must take place prior to open enrollment, and the findings must be submitted to CMS. CMS will review and approve auditors and DE entities for use of the proxy direct enrollment on a first come, first served basis, and cannot commit to reviewing and approving all auditors and DE entities prior to November 1, 2017.

To ensure Exchange systems are not negatively affected, DE entities wishing to participate in proxy direct enrollment will need to conduct testing with CMS. This testing will take place on a timeframe to be determined by CMS, likely in early September 2017. Additional information about proxy direct enrollment testing will be forthcoming.
CMS will review and approve DE entities requests to participate in proxy direct enrollment via the pre- open enrollment readiness review outlined at 45 C.F.R. § 155.220(c)(i)(3)(K) and 45 C.F.R. § 156.1230(b)(2). This readiness review will entail: review of third party audit findings, review of testing results, and establishment of operational protocols to ensure entity and Exchange systems stay in sync. We anticipate that we will begin notifying DE entities on a rolling basis of approval to use proxy direct enrollment in October, 2017. Proxy direct enrollment entities will be required to sign an agreement to participate in this pathway.

CMS will also continue to conduct standard web-broker website reviews that include, for example, reviews to determine compliance with display and QHP listing requirements, and will regularly review DE entities not participating in proxy direct enrollment to be sure the entity is using the approved redirect pathway. CMS will also conduct regular reviews of proxy direct enrollment entities' compliance with applicable requirements.

CMS will continue to maintain final authority and oversight over actions with respect to DE partner compliance with Exchange regulations.

Given the potential risks and the need for system stability during the shorter open enrollment period, CMS will invoke its authority[3] to temporarily suspend a DE entity's access to the FFE **immediately upon indication that an approved DE entity is out of compliance with requirements and guidance related to proxy direct enrollment**. Access will not be restored until the issue is remedied. Furthermore, any DE entity that does not obtain prior approval for proxy direct enrollment from CMS and is found to be using proxy direct enrollment will have its access to the FFE suspended until the entity is in compliance with an approved DE pathway.

CMS intends that the proxy direct enrollment pathway be temporary until the enhanced direct enrollment pathway under 45 C.F.R. § 155.220(c)(3)(ii) and 45 C.F.R. § 156.265 (b)(3) is available. Entities wishing to utilize the new proxy direct enrollment pathway must notify CMS of their intention to do so and must provide their third party auditor selection, including contact information. Entities may begin to notify CMS of their intent after the release of additional guidance and direction in mid-June.

If you have any questions on this guidance or require technical assistance, please contact webbroker@cms.hhs.gov.

3 45 C.F.R. § 155.220(c)(3)(i)(L) and 45 C.F.R. § 156.1230(b)(1).

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

## Now Available: Technical Assistance Resource Guide

The Centers for Medicare and Medicaid Services (CMS) has recently published the Technical Assistance Resource Guide, which concisely highlights all of the support that is available to clinicians participating in the Quality Payment Program. It contains brief summaries on each branch of technical assistance, contact information, and maps to illustrate coverage areas. You can access the Technical Assistance Resource Guide on qpp.cms.gov under the Education and Tools section, or download it directly via the following link: https://qpp.cms.gov/docs/QPP_Technical_Assistance_Resource_Guide.pdf.

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## Updated eCQM Specifications for Calendar Year (CY) 2018 Available on the eCQI Resource Center Website

The Centers for Medicare & Medicaid Services (CMS) posted the 2017 annual update for eCQMs for CY 2018 reporting for Eligible Hospitals and Critical Access Hospitals (CAHs), and CY 2018 performance for Eligible Professionals (EPs) and Eligible Clinicians. These updated eCQMs are fully specified and **may** be used to electronically report 2018 clinical quality measure data for CMS quality reporting programs. Measures will not be eligible for 2018 reporting unless and until they are proposed and finalized through notice-and-comment rulemaking for each applicable program.

CMS updates the specifications annually to align with current clinical guidelines and code systems so they remain relevant and actionable within the clinical care setting. All of the updated measure specifications have been re-specified using the Quality Data Model (QDM) 4.3-based Health Quality Measures Format (HQMF) version R 2.1.

CMS has updated eCQMs for potential inclusion in the following programs:

- The Hospital Inpatient Quality Reporting (IQR) Program
- The Medicare Electronic Health Record (EHR) Incentive Program for Eligible Hospitals and CAHs
- The Medicaid EHR Incentive Program for EPs, Eligible Hospitals and CAHs
- Quality Payment Program: The Merit-based Incentive Payment System (MIPS) for MIPS Eligible Clinicians and Alternative Payment Models

**Where to Find the Updated Measures**

The updated measure specifications are available on the Electronic Clinical Quality Improvement (eCQI) Resource Center for Eligible Hospitals and Critical Access Hospitals, and Eligible Professionals and Eligible Clinicians.

**Note:** The eCQMs and supporting materials are no longer available on the eCQM Library webpage of cms.gov. CMS plans to migrate all information on the library webpage to the eCQI Resource Center later this year.

**Provide Feedback on the Update Measures**

To report questions and comments regarding the updated measures, visit the ONC CQM Issue Tracker.

**For More Information**

To find out more about eCQMs, visit the eCQI Resource Center.

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## CMS Releases Lookup Tool to Help Clinicians Determine their MIPS Participation Status

Unsure of your participation status in the Merit-based Incentive Payment System (MIPS)? Clinicians can now use an interactive tool on the CMS Quality Payment Program website to determine if they should participate in the MIPS track of the Quality Payment Program in 2017.

To determine your status, enter your national provider identifier (NPI) into the entry field on the tool which can be found on the Quality Payment Program website at https://qpp.cms.gov/. Information will then be provided on whether or not you should participate in MIPS this year and where to find resources.

**Participation Criteria**

You will participate in MIPS in 2017 if you:

- Bill Medicare Part B more than $30,000 a year **AND**
- See more than 100 Medicare patients a year.

You must also be a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified nurse practitioner

If you are new to Medicare in 2017, you do not participate in MIPS. You may also be exempt if you qualify for one of the special rules for certain types of clinicians, or are participating in an Advanced Alternative Payment Model (APM). To learn more, review the MIPS Participation Fact Sheet.

**If you are not in the program in 2017, you can participate voluntarily and you will not be subject to payment adjustments.**

**Participation Notification Letters** – CMS recently sent letters in the mail notifying clinicians of their MIPS participation status. See a sample of the letter (zip) on the Education page of https://qpp.cms.gov/. This tool is another resource for clinicians to use to determine their status.

###

## HHS Partnership Center Newsletter: Introducing our New Director

The Partnership Center
Center for Faith-based and Neighborhood Partnerships
U.S. Department of Health and Human Services

Dear Friends,

My name is Shannon Royce and I am delighted to have this opportunity to serve as the Director for the Center for Faith-based and Neighborhood Partnerships at the U.S. Department of Health and Human Services. In this position I am privileged to work with Jane Norton, Director of the Office of Intergovernmental and External Affairs.

I am eager to work with our faith and community partners in your efforts of service and stewardship to bring help and healing in your communities. In doing so, I believe our work can help HHS fulfill its mission to enhance and protect the health and well-being of all Americans. You are instrumental partners in addressing community needs and concerns in the work you do every day, serving your members and neighbors and meeting the needs of our most vulnerable citizens.

Whether you are opening your doors to programs and services, mobilizing, educating, and training members or community volunteers, we look forward to joining with you to address the HHS priorities for a healthier America: opioid addiction, childhood obesity, serious mental illness, and health reform.

As we look ahead, I would like to highlight one of those priorities and consider how we can move forward together on the issue of opioid addiction. Just last month, Secretary Price announced the HHS Strategy for fighting the Opioid Crisis. In his speech, he acknowledged that 90 percent of Americans struggling with addiction are not getting treatment. We know that faith and community leaders witness those suffering with addiction and may be the first connection to help. As we consider how to strengthen the response of community leaders to address the crisis of substance abuse in their communities, we hope you will join the conversation. In that conversation, know you will have a strong partner in Secretary Price. Toward the end of his speech, Secretary Price said the following,

"Addiction isn't a moral failing, but the addicted person is a moral agent. He may be enslaved to drugs, but he is not a slave. He may have lost control of his life, but he has not been robbed of his free will or his God-given ability to bear the greatest burdens in life and come out on the other end stronger for it.

The Apostle Paul writes in his first letter to the Corinthians: "No temptation has overtaken you except what is common to mankind. And God is faithful; he will not let you be tempted beyond what you can bear. But when you are tempted, he will also provide a way out so that you can endure." As a nation, we can endure this temptation. But none of us — no person, no family, no community — can do it alone.

It is only with your help that, as a nation, we can find a way out for every American struggling with addiction."

That help can come from faith-based and community partners just like you. Let us know what is effective in your community as we work together to build best practices to fight the scourge of this devastating epidemic. We'll be reaching out to you and welcome the opportunity to hear from you.

The team at the HHS Center for Faith-based and Neighborhood Partnerships may be reached at (202) 358-3595 and by email at partnerships@HHS.gov. Follow me on Twitter: @jcnjmama and the Center @PartnersforGood.

Warmly,

Shannon Royce, Esq.

Center for Faith-based & Neighborhood Partnerships

Office of Intergovernmental and External Affairs

Department of Health and Human Services

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## March 2017 Medicaid and CHIP Application, Eligibility Determination, and Enrollment Report and Data Highlights

Today the Centers for Medicare & Medicaid Services (CMS) released a monthly report on state Medicaid and Children's Health Insurance Program (CHIP) data represents state Medicaid and CHIP agencies' eligibility activity for the calendar month of March 2017. The report is one of a series of reports on state Medicaid and CHIP data, and it includes data reported by states. This report measures eligibility and enrollment activity for the entire Medicaid and CHIP programs in all states , reflecting activity for all populations receiving comprehensive Medicaid and CHIP benefits in all states, including states that have not yet chosen to adopt the new low-income adult group established by the Affordable Care Act.

This data is submitted to CMS by states using a common set of indicators designed to provide information to support program management and policy-making related to application,

eligibility, and enrollment processes. As with previous reports, this month's report focuses on those indicators that relate to the Medicaid and CHIP application and enrollment process.

Click here to view the report (PDF):
https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

Read additional background information about the monthly enrollment report.

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## CMS Announces Extension for States under Medicaid Home and Community-Based Settings Criteria

*Agency reinforces partnership with states in administering Medicaid Program*

**WASHINGTON D.C.; May 09, 2017 -** The Centers for Medicare & Medicaid Services (CMS) announced a three-year extension for state Medicaid programs to meet the Home and Community Based Services (HCBS) settings requirements for settings operating before March 17, 2014. This extension is in response to states' request for more time to demonstrate compliance with the regulatory requirements and ensure compliance activities are collaborative, transparent, and timely.

"Medicaid programs are strongest when states have time to engage with beneficiaries and their families to ensure these programs fit their choices and needs," said CMS Administrator Seema Verma. "Extending the HCBS compliance period by three years allows states to work more closely with those they serve, so they can increase the quality of care and minimize the potential for unnecessary disruption in services."

Today's announcement builds on a joint commitment from Health and Human Services (HHS) Secretary Tom Price and CMS Administrator Seema Verma to partner with states in improving the Medicaid program and the lives of those it serves. In the March 14, 2017 letter to governors, the HHS leaders laid out a vision of partnership that would provide high quality, sustainable, health care to those who need it most. "We commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population."

States now have until March 17, 2022 to demonstrate compliance with the final rule. For more information, please visit: http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html

###

# *Upcoming Webinars and Events and Other Updates*

## Upcoming Webinar: Join CMS on May 22nd to Learn More about the Quality Payment Program Participation Requirements

On Monday, May 22nd at 1:00 PM ET, the Centers for Medicare & Medicaid Services (CMS) will host an overview webinar on the participation criteria used to determine inclusion in the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

**Webinar Details**
**Title:** Quality Payment Program Participation Criteria Webinar
**Date**: Monday, May 22, 2017
**Time:** 1:00 – 2:00 PM ET
**Description:** During this webinar, CMS will explain:
- An overview of MIPS participation requirements for individual clinicians and groups
- Participation requirements for Advanced APMs and MIPS APMs
- A new tool that allows clinicians to check if they are included in MIPS
- The recent participation letter sent to clinician offices

**Event Registration:** https://engage.vevent.com/rt/cms/index.jsp?seid=828

The audio portion of this webinar will be broadcast through the web. You can listen to the presentation through your computer speakers. If you cannot hear audio through your computer speakers, please contact CMSQualityTeam@ketchum.com. Phone lines will be available for the Q&A portion of the webinar.

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## Now Open for Registration: Medicare and the Marketplace for Agents and Brokers


Click here to access the AB Update

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## Medicare Learning Network Publications & Multimedia

### News & Announcements

- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply May 1 through 31
- Clinical Laboratories: Lab Data Due May 30
- SNF Quality Reporting Program: Submission Deadline Extended to June 1
- National Mental Health Awareness Month 2017

### Provider Compliance

- Reporting Changes in Ownership

### Claims, Pricers & Codes

- 2018 ICD-10-PCS Files Available

### Upcoming Events

- Quality Payment Program Participation Criteria Webinar — May 22
- National Partnership to Improve Dementia Care and QAPI Call — June 15

### Medicare Learning Network Publications & Multimedia

- Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training Course — Reminder

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