

# CMS Region 7 Updates

03/31/2016

## ***ACA/Marketplace Updates***

### **CMS Strong Start for Mothers and Newborns Strategy II Initiative: Second Annual Evaluation Report**

We, at the Centers for Medicare & Medicaid Services (CMS), are pleased to announce findings from the second annual evaluation report for the Strong Start for Mothers and Newborns Strategy II Initiative. As noted with the release of our first annual report, Strong Start Strategy II seeks to build on work conducted by the Partnership for Patients and Strong Start Strategy I to improve newborn health through a reduction in early elective deliveries. Babies are generally healthier and have better long-range outcomes when they are born full-term. Strategy I contributed to a 64.5% nationwide drop in early elective deliveries from 2010 to 2013.

The Strong Start II (hereafter referred to as Strong Start) builds on this success through prenatal care enhancements addressing the psychosocial needs of pregnant women eligible for Medicaid and CHIP. Strong Start is an important federal initiative geared toward testing innovative approaches to improve maternal and infant health outcomes in low-income families.

Research consistently shows that infants born preterm (before 37 completed weeks of gestation) have higher mortality risks and may endure a lifetime of developmental and health problems when compared to their counterparts born after 37 weeks' gestation.

Prenatal care enhancements provided through Strong Start are designed to promote overall maternal and infant health and particularly to reduce incidence of preterm birth and low birth weight. The second annual report presents the progress Strategy II has made since its inception.

Strong Start has continued its partnership with 27 organizations representing nearly 200 provider sites in 32 states, Washington, D.C., and Puerto Rico. The program continues to provide enhanced services through three approaches:

- Group Care – Group prenatal care that incorporates peer-to-peer support in a facilitated setting for three components: health assessment, education, and support.
- Birth Centers – Comprehensive prenatal care facilitated by midwives and teams of health professionals, including peer counselors and doulas.
- Maternity Care Homes – Enhanced prenatal care at traditional prenatal sites with enhanced continuity of care and expanded access to care coordination, education, and other services.

Enrollment increased dramatically in the second year of program operations, with a total of 23,000 women enrolled from March 2013 to the end of the first calendar quarter of 2015. Enrollment is expected to continue to grow to more than 40,000 participants by the program's end in February 2017. Additionally, participants continue to express overwhelming satisfaction, with 90% stating that they were either very satisfied or extremely satisfied with their prenatal care.

In addition to their standard schedule of prenatal care visits, Strong Start participants receive enhanced care visits in accordance with their psychosocial needs. Enhanced visits provide services such as care coordination, referrals to local resources, prenatal health education, and peer support.

Upon enrollment, Strong Start participants have several risk factors, including many pertaining to psychosocial needs:

- Depression upon enrollment (nearly a quarter of participants report being depressed at intake)
- Unstable housing
- Unemployment
- Unmet mental health and dental needs
- Food insecurity
- Unmarried or unpartnered status

Results from the second year evaluation indicate that, as was found in the first year, Strong Start participants have:

- Lower rates of cesarean section than national averages, though there is wide variation among and within models
- Higher rates of breastfeeding than national averages among similar populations

In addition, the new report finds that Strong Start participants have:

- Overall preterm birth rates similar to national averages despite the high-risk population served
- Lower preterm birth rates than national averages within racial-ethnic groups (Black, White, Hispanic)
- Vaginal birth after cesarean rates that are nearly twice the national average

Although findings must be interpreted with caution because they are descriptive, we are pleased with what we have found thus far. <sup>[1]</sup> Substantial progress was made during the second evaluation year in developing resources, particularly obtaining state Medicaid claims linked to vital records, which will enable development of a control group and an analysis of costs. The

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<sup>[1]</sup> Findings thus far cannot be directly attributed to Strong Start. Comparisons with national averages do not control for important factors, such as risk profiles or demographics. In future reports, linked Medicaid claims and vital records data will be the basis for a controlled comparison.

third annual report is anticipated to contain analysis of further participant-level data, case studies based on site visits, and an initial analysis of linked data from states.

Much work remains to be done to reduce significant risks and complications for pregnant women and infants, but these early results from the Strong Start evaluation show promise for improving pregnancy outcomes. We remain committed to working together to deliver higher quality care, smarter spending, and better health outcomes for low-income pregnant women and their newborns.

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## **Agent and Broker Roadmap to Resources**

Be sure to take a look at the "[Agent and Broker Roadmap to Resources](#)" in the "Guidance" section of the [Agents and Brokers Resources webpage](#).

The Roadmap to Resources:

- Presents resources, such as checklists and troubleshooting tips to make it easier and faster for you to help consumers
- Serves as a quick reference guide for resources you may find helpful as you navigate the Health Insurance Marketplace and assist individuals and small businesses select, enroll in, and use coverage
- Explains coverage options available to consumers in the Marketplace

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## **News for Federally-facilitated Marketplace Agents and Brokers - March 2016 Edition**

An electronic source of information for Federally-facilitated Marketplace (FFM) Agents and Brokers

### **In This Issue:**

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## **Resources for Agents and Brokers**

### ***The “Final 2017 HHS Notice of Benefit and Payment Parameters” is Now Available***

CMS issued the [“Final 2017 HHS Notice of Benefit and Payment Parameters”](#) on March 1, 2016. CMS also released a [fact sheet](#) with details on key provisions of the final Notice of Benefit and Payment Parameters for 2017. One of the key provisions includes finalizing the Open Enrollment period for future years:

- For coverage in 2017 and 2018, Open Enrollment will begin on November 1 of the previous year and run through January 31 of the coverage year.
- For coverage in 2019 and beyond, Open Enrollment will begin on November 1 and end on December 15 of the preceding year (e.g., November 1, 2018 through December 15, 2018 for 2019 coverage).

### ***The “2017 Letter to Issuers in the Federally-facilitated Marketplaces” is Now Available***

CMS released its final [“2017 Letter to Issuers in the Federally-facilitated Marketplaces”](#) on February 29, 2016. This letter provides issuers interested in offering coverage in FFM states information on key dates for the qualified health plan (QHP) certification process, standards that will be used to evaluate QHPs for certification, procedures for oversight of agents and brokers, and consumer support policies and programs.

### ***Upcoming Small Business Health Operations Program (SHOP) Marketplace Webinar***

CMS will host a webinar on how agents and brokers can use the SHOP Marketplace effectively on April 20 from 1:00 – 2:30 PM Eastern Time (ET). This webinar will cover the benefits of the SHOP Marketplace for agents and brokers. It will explain how to access training on the SHOP Marketplace Agent/Broker Portal, and on the SHOP Marketplace employer and employee application.

To register for the webinar, please log in to [www.REGTAP.info](http://www.REGTAP.info). If you have questions on the webinar registration process, visit the new “Upcoming Agent and Broker Webinars” section of the [Agents and Brokers Resources webpage](#) for more information.

### ***The “Open Enrollment and Beyond” Presentation Slides Are Now Available***

CMS has created the [“Open Enrollment and Beyond”](#) presentation slides as a resource to help agents and brokers as they assist consumers post-Open Enrollment. The plan year 2016 Open

Enrollment period for the FFM ended on January 31, 2016; however, there are still a number of ways that you can assist consumers.

- Some consumers are still eligible to enroll in Marketplace coverage. You can continue to provide enrollment assistance to these consumers.
- Consumers who are already enrolled in coverage may have questions or concerns regarding how to use their coverage.
- You can continue to build relationships with your community and provide outreach and education for consumers about the Affordable Care Act and health insurance.

### **Help Consumers Go from Coverage to Care**

CMS has created the Coverage to Care initiative to help people with new health care coverage understand their benefits and connect to the primary care and preventive services that are right for them. Please take a moment to review the many [written resources and videos](#) you can use to help consumers understand how to navigate their health coverage.

### **Tax Readiness**

#### **Marketplace Call Center or the Internal Revenue Service (IRS) – Where to Refer Consumers with Tax-Related Questions**

This chart provides a reference on when consumers should contact the Marketplace Call Center or the IRS if they have questions about how their coverage status and/or Marketplace financial assistance will affect the tax filing process. Use this resource in your work with consumers to help route their questions accordingly.

<b>Marketplace Call Center will handle questions regarding:</b>	<b>Internal Revenue Service will handle questions regarding:</b>
<ul style="list-style-type: none"> <li>• Form 1095-A, “Health Insurance Marketplace Statement”</li> <li>• Form 8962, “Premium Tax Credit (PTC),” and how it works with Form 1095-A</li> <li>• Advance payments of the premium tax (APTC) credit versus PTC</li> <li>• Eligibility for APTC</li> <li>• Exemptions, including who qualifies for exemptions, what to do if your exemption is pending, and how to get an Exemption Certificate Number</li> <li>• Handling problems with Form 1095-A (e.g., missing or incomplete information, duplicate copies)</li> <li>• How the PTC may impact consumers’ tax refunds</li> <li>• Fee for not having coverage (what it is, how much it will cost, what it will be in future years)</li> <li>• Tax assistance, including free file, which forms to fill out, where to get assistance with tax filing, and what the tax deadline is</li> </ul>	<ul style="list-style-type: none"> <li>• Help filing taxes</li> <li>• Help paying taxes owed to the IRS</li> <li>• Questions related to tax filing, such as:               <ul style="list-style-type: none"> <li>○ How long can I delay filing?</li> <li>○ What happens if I don’t file?</li> <li>○ I filed my taxes prior to getting Form 1095-A. How do I amend my tax return?</li> </ul> </li> <li>• Questions on how to complete Form 8962</li> <li>• Questions on how to complete Form 8965, “Health Coverage Exemptions”</li> <li>• Questions about other tax form</li> </ul>

## ***New Tax Tool Available at Healthcare.gov***

HealthCare.gov now includes a new [Tax Tool feature](#) that streamlines the consumer experience by combining last year's Second-lowest Cost Silver Plan and Lowest-cost Bronze Plan tools into one tool. This change will support consumers in calculating amounts for both the PTC using IRS Form 8962 and the affordability exemption using IRS Form 8965. In addition, the new tax tool will support consumers with reconciling APTC for tax years 2014 and 2015; provide opportunities for consumers to print, save, or email their results; and offer consumers instructions on what to do next.

## ***Helping Consumers Avoid Tax Fraud***

In your work with consumers, please let them know that there are reports of consumers being targeted by tax scams. If consumers owe a fee for not maintaining minimum essential coverage (MEC), let them know that payment should be made only with their federal income tax return or in response to a letter from the IRS. The payment should never be made directly to an individual or tax preparer.

Also, let consumers know that if they are not United States citizens or nationals and are not lawfully present in the United States, they are exempt from the fee and do not need to make a payment. For this purpose, immigrants with Deferred Action for Childhood Arrivals (DACA) status are considered not lawfully present and are, therefore, exempt.

Below are hyperlinks to additional information you can share with consumers to help prevent them from being victims of fraud:

- [Affordable Care Act Consumer Alert: Choose Your Tax Preparer Wisely](#)
- [Affordable Care Act Consumer Alert: Choose Your Tax Preparer Wisely \(Spanish Version\)](#)
- [Tips for Choosing a Tax Professional](#)
- [Make a Complaint About a Tax Return Preparer](#)

## ***SHOP Marketplace Corner - Come In, We're Open***

The SHOP Marketplace is open all year long. Small employers can still offer their employees' health and dental insurance through the SHOP Marketplace at HealthCare.gov. SHOP Marketplace applications submitted by the 15th of the month may go into effect as soon as the first of the following month.

## ***New 2016 SHOP Marketplace Enrollment Materials Now Available***

New step-by-step user guides and videos are now available to help you walk small employers, employees, and agents and brokers through the 2016 SHOP Marketplace application, enrollment, renewal, and payment process.

Watch all of the SHOP Marketplace enrollment and renewal videos on the [SHOP Marketplace YouTube Playlist](#).

Access the SHOP Marketplace user guides at the links below:

- [Employer User Guide](#)
- [Employee User Guide](#)
- [Agent Broker User Guide](#)
- [Billing and Payment User Guide](#)
- [Renewal User Guide](#)

## ***It's Tax Season! Help Small Employers Apply for the Tax Credit***

Small employers with fewer than 25 full-time equivalent employees who offer health insurance coverage through the SHOP Marketplace may be eligible for a Small Business Health Care Tax Credit.

To find out if a small employer may be eligible to receive the Small Business Health Care Tax Credit, check out the [SHOP Tax Credit Estimator](#) available at HealthCare.gov. For more information on the Small Business Health Care Tax Credit, please visit [IRS.gov](#).

Remember: To assist small employers in the SHOP Marketplace, you must first establish your profile on the [SHOP Marketplace Agent/Broker Portal](#). Once you've established your profile, small employers will be able to authorize you to assist with their SHOP Marketplace application and enrollment.

Need help? Visit [HealthCare.gov/small-businesses](http://HealthCare.gov/small-businesses) or contact the SHOP Call Center at 1-800-706-7893 (TTY: 711) Monday through Friday from 9:00 AM to 7:00 PM ET.

## **Spotlight on Eligibility and Enrollment**

### ***Final Enrollment Numbers for Open Enrollment 2016***

On January 31, the plan year 2016 Open Enrollment period closed. About 12.7 million consumers selected plans or were automatically reenrolled across all states, either through HealthCare.gov or a State-based Marketplace, Department of Health & Human Services Secretary Sylvia M. Burwell announced. This figure does not include about 400,000 people who signed up on the New York and Minnesota Marketplaces for coverage through the Basic Health Program during this Open Enrollment period.

To read a fact sheet with a sharable video, visit:

<http://www.hhs.gov/about/news/2016/02/04/fact-sheet-about-127-million-people-nationwide-are-signed-coverage-during-open-enrollment.html>.

To read the CMS Weekly enrollment snapshot with data (including state and regional data) through February 1, 2016, visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html>.

### ***Special Populations – Newlyweds Enrolling in the Marketplace Outside of Open Enrollment***

While the plan year 2016 Open Enrollment period is now closed, getting married triggers a special enrollment period (SEP) that allows consumers to enroll in a QHP outside of the Open Enrollment period. Help consumers by reminding them that the SEP for marriage is available to all qualified consumers, even if they were previously not enrolled in a QHP. Newly married consumers who are already enrolled in QHPs will be eligible to change

QHPs if they want to or add their dependents (new spouses) to their existing plans, if they receive an SEP.

Be sure to remind consumers they must report a life event like marriage to the Marketplace to claim their SEP. Consumers should be sure to terminate any coverage that is no longer applicable. Consumers have 60 days (30 days in SHOP) from the date of marriage to use this SEP and select QHPs. The Marketplace will also calculate whether the change in status will affect the newly married consumers' coverage options or eligibility for APTC and cost-sharing reductions (CSR). For more information, check out [Helping Newlyweds Enroll in the Marketplace Outside Open Enrollment](#).

### **Help Consumers Report a Life Change or Change in Circumstances through the Marketplace**

It is important to remind consumers that once they have Marketplace coverage, they must report certain life changes. That information may change the coverage consumers are eligible for and whether they may be eligible for an SEP. It may also make a difference in the amount of APTC or CSR a consumer is eligible for and the premiums they pay.

- For more information about what changes should be reported to the Marketplace, see the ["Helping Consumers Report a Life Event or Change in Circumstance"](#) presentation slides.
- For step-by-step instructions explaining how to report a life change at HealthCare.gov, including screenshots, please review slides 19 through 21 of the ["Weekly Updates for Agents and Brokers Participating in the FFM for Plan Year 2016 Open Enrollment—Week 3"](#) webinar slides.

### **Did You Know?**

Most people must have qualifying health coverage or pay a fee for the months they do not have insurance. However, some consumers qualify for a health coverage exemption and do not need to have health insurance or pay the fee.

Exemptions are available based on a number of circumstances, including certain hardships, some life events, health coverage or financial status, and membership in some groups. Consumers claim some health coverage exemptions on their federal income tax return. Other exemptions require the consumer to apply with a paper application.

If you are helping a consumer with this process, remind them they do not have to pay the fee for any month they are covered by a plan that qualifies as MEC.

To learn more about health coverage exemptions, see the resources located at HealthCare.gov on the [Exemptions from the requirement to have health insurance](#) webpage, as well as slides 20 through 26 of the ["Weekly Updates for Agents and Brokers Participating in the FFM for Plan Year 2016 Open Enrollment—Week 13"](#) webinar slides.

### **Follow Us on Twitter**

You can find important information and updates by following the CMS and HealthCare.gov Twitter handles ([@CMSGov](#) and [@HealthCareGov](#)) or by searching for the hashtags #ABFFM or #ABFFSHOP on Twitter.

### **Contact Us**

For questions pertaining to the FFM agents and brokers program, including FFM registration requirements, or to subscribe to this newsletter, please contact the FFM Producer and Assister Help Desk via email at: [FFMProducer-AssisterHelpDesk@cms.hhs.gov](mailto:FFMProducer-AssisterHelpDesk@cms.hhs.gov).

You may also contact the Agent and Broker Call Center by calling 1-855-CMS-1515 (855-267-1515) and selecting option "1." Call Center Representatives are available Monday through Saturday from 8:00 AM to 10:00 PM ET.

This call center does not have access to consumer information and is not able to handle specific questions or issues with a consumer's application. Please continue to call the Marketplace Call Center at 1-800-318-2596 for assistance related to enrolling consumers in coverage through the Individual Marketplace. For assistance related to coverage through the SHOP Marketplace, contact the SHOP Call Center at 1-800-706-7893.

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## **Statement by the President on the Sixth Anniversary of the Affordable Care Act**

Just six years ago, the reality in our country was that millions of Americans were locked out of our health care system because they couldn't afford insurance or because they had pre-existing conditions. Women were charged more than men simply because they were women. People who needed coverage the most were too often denied it.

At the same time, rising health care costs posed a significant threat to our economy, eroding workers' paychecks and adding to our deficits. And while costs were high, the quality of care often wasn't.

The good news is, we've taken significant strides to change that. Tomorrow marks six years since I signed the Affordable Care Act into law. Thanks to this law, 20 million more Americans now know the security of having health insurance, and our uninsured rate is below ten percent for the first time on record. As many as 129 million people with pre-existing conditions can no longer be denied coverage or charged more as a result. Those with private insurance got an upgrade as well: now almost 140 million Americans are guaranteed free preventive care, like certain cancer screenings and vaccines, and improvements in the quality of care in hospitals have averted 87,000 deaths since 2010.

We're also making historic investments to make sure our health care system puts patients first. We're paying doctors for what works, improving the safety and effectiveness of health care that patients receive. We're helping doctors and hospitals coordinate with each other by unlocking health data. And we're giving patients more information and tools to stay healthy.

Critics said this law would destroy jobs and cripple the economy, but in fact just the opposite has happened. Our businesses have added jobs every single month since I signed it into law. The unemployment rate has dropped from almost 10 percent to 4.9 percent. Thanks in part to this law, health care prices have risen at the lowest rate in 50 years. Medicare is continuing a period of slow spending growth, saving taxpayers more than \$470 billion from 2009 to 2014 alone. And premiums for a family with job-based coverage are almost \$2,600 lower than if trends from the decade before the law had continued.

We've made good progress in the last six years. But we still have more work to do. We'll keep working to get more Americans covered and help the millions of people who remain uninsured in states that rejected the Medicaid expansion option. We'll keep working to make insurance and prescription drugs more affordable. And we'll keep working to reduce costs and improve the quality of care throughout our health system.

But the facts are clear: America is on a stronger footing because of the Affordable Care Act. Six years later, this is no longer just about a law. It's not about politics. It's about the recent college graduate who can stay on his parents' health insurance until he's 26. It's about the working mom who has coverage because her state expanded Medicaid. It's about the entrepreneur who has the freedom to pursue her dream and start that new business. After nearly a century of effort, and thanks to the thousands of people who fought so hard to pass and implement this law, we have at last succeeded in leaving our kids and grandkids a country where pre-existing conditions exclusions are a thing of the past, affordable options are within our reach, and health care is no longer a privilege, but a right.

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## **Marketplace Form 1095-A Corrections**

At this time, the Marketplace estimates that Form 1095-A correction requests may take more than 30 days to complete. Consumers who request a correction now may not get a determination regarding their correction requests in time to meet the April 18th IRS deadline to file 2015 federal income taxes. Consumers waiting on a Form 1095-A correction from the Marketplace should contact a tax preparer or go to [www.irs.gov](http://www.irs.gov) to find out what to do next, which could include requesting an extension to file 2015 federal income taxes. Let consumers know that an extension to file a tax return doesn't give the consumer more time to pay any taxes that may be due.

Here are some answers to frequently asked questions about Form 1095-A corrections:

### **Q: What happens after the consumer believes their Form 1095-A to be incorrect and contacts the Marketplace call center?**

A: Marketplace Call Center Representatives enter consumer requests into the Health Insurance Casework System (HICS) for review by the Form 1095-A Issue Resolution Team. The Issue Resolution Team will review the request and contact the consumer via telephone when a determination regarding the Form 1095-A correction has been made. During the telephone call, the Issue Resolution Team Representative will let the consumer know whether the request to correct the Form 1095-A has been approved or denied and next steps to take depending on the determination. The Form 1095-A Issue Resolution Team will not call the consumer regarding an address change or reprint request.

### **Q: How long does the Marketplace have to review and correct a 1095-A initiated by a consumer?**

A: The Form 1095-A Issue Resolution Team may take 30 days or more to review a correction request, make a determination and notify the consumer.

### **Q: If the consumer doesn't agree with the Issue Resolution Teams' determination of their 1095-A correction request, can the consumer request secondary review of the 1095-A correction request?**

A: Yes, the consumer can request a secondary review of their initial Form 1095-A correction request. To initiate the secondary review, the consumer should make the request with the Form 1095-A Issue Resolution Team when the representative calls to communicate the initial correction request determination. If after the secondary review, the initial determination is upheld, the consumer can file a "Statement of Disagreement." Instructions on how to file the statement will be included in the denial letter sent to the consumer.

## From Coverage to Care (C2C) Initiative

The CMS Office of Minority Health is launching the [From Coverage to Care \(C2C\)](#) initiative in April. This effort is designed to help consumers learn how to navigate their health care, understand their benefits, select a primary health provider, and begin to regularly seek preventive and chronic care management services.

Assisters are encouraged to participate in the initiative, which will last three months. C2C has made the following resources available to assisters to help consumers use their healthcare:

- Partnership Toolkit: Includes ways to collaborate, ideas for events, print/online resources, prepared blogs and social media posts.
- 5 Ways to Make the Most of Your Health Coverage
- Roadmap to Better Care and a Healthier You

These resources, in addition to several other consumer and assister tools (in multiple languages), are available at <http://go.cms.gov/c2c>.

### Refresher on Hardship Exemptions

Assisters can help consumers understand if they qualify for a hardship exemption and help them fill out the application and submit documentation.

[Click here](#) for a list of hardship exemptions and more information about how to apply for them. Only one exemption is needed for any given time period. Consumers may select multiple hardship exemptions on one application, but must send in documentation for each type requested.

The duration of the hardship exemption varies depending on the type, but is usually granted for one month prior to, during, and one month after the hardship event. Consumers can apply for hardship exemptions at any time.

### Quick Question: Mailing Paper Applications

#### **Can assisters mail a paper application on a consumer's behalf?**

Yes, as long as the consumer consents to the assister's retaining the application for this purpose. Assisters can add a specific consent to the [Navigator](#) or [CAC](#) model authorization form so that consumers can consent to having their application mailed on their behalf. This consent may be particularly useful for navigators working with farmworkers or other mobile populations.

### New 2016 SHOP Marketplace Enrollment Materials Now Available

New step-by-step user guides and videos are now available to walk employers and employees through the 2016 SHOP Marketplace application, enrollment, renewal and payment process.

Watch all of the SHOP Marketplace enrollment and renewal videos on the [SHOP Marketplace YouTube Playlist](#).

Access the SHOP Marketplace user guides at the links below:

- [Employer User Guide](#)
- [Employee User Guide](#)
- [Renewal User Guide](#):

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## New Assister Resources

- Helping COFA Migrants Enroll in Coverage: [Fact Sheet](#) for Assisters
- Overview of the Final Notice of Benefit and Payment Parameters for 2017 (Assister Webinar): The March 18, 2016 assister webinar included an overview of the assister provisions in the Final Notice of Benefit and Payment Parameters for 2017. The presentation includes a summary of the new Navigator post-enrollment and other assistance activities, and new reporting requirements for CACs. Click [here](#) to view the slides from that presentation. Click [here](#) to read the Final Notice of Benefit and Payment Parameters for 2017.

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## Delivery System Reform (DSR)

Today, HHS released a new whiteboard video succinctly describing the Department's focus on better care, smarter spending and healthier people – otherwise known as Delivery System Reform (DSR). Further, a new blog is now available providing a 101 orientation to DSR.

To view an **article** released today **featuring the Department's focus on DSR** as it achieves historic gains in providing 20 million Americans with access to health care, visit:

<http://www.statnews.com/2016/03/22/obamacare-delivery-reform/>

To view the **DSR 101 blog** visit: [Delivery System Reform: Making Health Care Work Better for Everyone](#)

To view the **whiteboard video**, visit: [HHS Whiteboard on Delivery System Reform](#)

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## Consumer Alert: Scammers Change Tactics, Once Again

Aggressive and threatening phone calls by criminals impersonating IRS agents remain a major threat to taxpayers, but now the IRS is receiving new reports of scammers calling under the guise of verifying tax return information over the phone.

The latest variation being seen in the last few weeks tries to play off the current tax season. Scam artists call saying they have your tax return, and they just need to verify a few details to process your return. The scam tries to get you to give up personal information such as a Social Security number or personal financial information, such as bank numbers or credit cards.

“These schemes continue to adapt and evolve in an attempt to catch people off guard just as they are preparing their tax returns,” said IRS Commissioner John Koskinen. “Don’t be fooled. The IRS won’t be calling you out of the blue asking you to verify your personal tax information or aggressively threatening you to make an immediate payment.”

The IRS reminds taxpayers to guard against all sorts of con games that continually change. The IRS, the states and the tax industry came together in 2015 and launched a public awareness campaign called [Taxes. Security. Together.](#) to help educate taxpayers about the need to maintain security online and to recognize and avoid “phishing” and other schemes.

The IRS continues to hear reports of phone scams as well as e-mail phishing schemes across the country.

“These schemes touch people in every part of the country and in every walk of life. It’s a growing list of people who’ve encountered these. I’ve even gotten these calls myself,” Koskinen said.

This January, the Treasury Inspector General for Tax Administration (TIGTA) announced they have received reports of roughly 896,000 phone scam contacts since October 2013 and have become aware of over 5,000 victims who have collectively paid over \$26.5 million as a result of the scam. Just this year, the IRS has seen a 400 percent increase in phishing schemes.

### **Protect Yourself**

Scammers make unsolicited calls claiming to be IRS officials. They demand that the victim pay a bogus tax bill. They con the victim into sending cash, usually through a prepaid debit card or wire transfer. They may also leave “urgent” callback requests through phone “robo-calls,” or via a [phishing email](#). They’ve even begun politely asking taxpayers to verify their identity over the phone.

Many phone scams use threats to intimidate and bully a victim into paying. They may even threaten to arrest, deport or revoke the license of their victim if they don’t get the money.

Scammers often alter caller ID numbers to make it look like the IRS or another agency is calling. The callers use IRS titles and fake badge numbers to appear legitimate. They may use the victim’s name, address and other personal information to make the call sound official.

Here are some things the scammers often do but the IRS will not do. Any one of these five things is a tell-tale sign of a scam.

### **The IRS will never:**

- Call to demand immediate payment over the phone, nor will the agency call about taxes owed without first having mailed you several bills.
- Call or email you to verify your identity by asking for personal and financial information.
- Demand that you pay taxes without giving you the opportunity to question or appeal the amount they say you owe.
- Require you to use a specific payment method for your taxes, such as a prepaid debit card.
- Ask for credit or debit card numbers over the phone or email.
- Threaten to immediately bring in local police or other law-enforcement groups to have you arrested for not paying.

If you get a phone call from someone claiming to be from the IRS and asking for money or to verify your identity, here’s what you should do:

### **If you don’t owe taxes, or have no reason to think that you do:**

- Do not give out any information. Hang up immediately.
- Contact TIGTA to report the call. Use their "[IRS Impersonation Scam Reporting](#)" web page. You can also call 800-366-4484.
- Report it to the Federal Trade Commission. Use the "[FTC Complaint Assistant](#)" on FTC.gov. Please add "IRS Telephone Scam" in the notes.

**If you know you owe, or think you may owe tax:**

- Call the IRS at 800-829-1040. IRS workers can help you.

**IRS YouTube Video**

- *Tax Scams:* [English](#) | [Spanish](#) | [ASL](#)
- *Security Summit Identity Theft Tips Overview:* [English](#)
- *Be Cautious When Using Wi-Fi:* [English](#)
- *Update Your Password Regularly:* [English](#)

Stay alert to scams that use the IRS as a lure. Tax scams can happen any time of year, not just at tax time. For more, visit "[Tax Scams and Consumer Alerts](#)" on IRS.gov.

Each and every taxpayer has a set of fundamental rights they should be aware of when dealing with the IRS. These are your [Taxpayer Bill of Rights](#). Explore your rights and our obligations to protect them on IRS.gov.

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# Medicare and Medicaid Updates

## FRAUD ADVISORY: SSA OIG Warns Public About "Disability Services" Phone Calls

Social Security Inspector General Patrick P. O'Carroll is warning citizens to be aware of phone calls from unknown people who claim to have information about a citizen's application for disability benefits and offer assistance with the citizen's claim. The Office of the Inspector General received a report from a Maryland citizen who recently received several of these phone calls, even though the citizen had not applied for disability benefits.

The callers appear to be "phishing" for personal information—such as Social Security numbers or personal financial information—from unknowing citizens, who possibly have applied for disability benefits and thus might be inclined to provide information to the caller in furtherance of his or her claim.

[See the full advisory at the OIG website.](#)

###

## CMS Releases Interactive Mapping Medicare Disparities Tool

The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) released a new interactive map to increase understanding of geographic disparities in chronic disease among Medicare beneficiaries. The [Mapping Medicare Disparities \(MMD\) Tool](#) identifies disparities in health outcomes, utilization, and spending by race and ethnicity and geographic location. Understanding geographic differences in disparities is important to informing policy decisions and efficiently targeting populations and geographies for interventions.

"Our commitment to health equity begins with properly measuring the care people get and having an honest dialogue on how and where we need to improve," said CMS Acting Administrator Andy Slavitt. "Today's tool aims to make it harder for disparities to go unaddressed."

Racial and ethnic minorities experience disproportionately high rates of chronic diseases, and are more likely to experience difficulty accessing high quality of care than other individuals. The identification of areas with large differences in the proportions of Medicare beneficiaries with chronic diseases is an important step for informing and planning health equity activities and initiatives. The Mapping Medicare Disparities Tool features:

- A dynamic interface with data on the prevalence of 18 chronic conditions, end stage renal disease, or a disability; Medicare spending, hospital and emergency department (ED) utilization, preventable hospitalizations, readmissions, and mortality rates.
- The ability to sort by state or county of residence, sex, age, dual-eligibility for Medicare and Medicaid, and race and ethnicity.
- Built-in benchmarking features to investigate disparities within counties and across racial and ethnic groups, and within racial and ethnic groups across counties.

“It’s not enough to improve average health care quality in the U.S.,” said CMS OMH Director Cara James. “As the CMS Equity Plan lays out, we must identify gaps in quality of care at all levels of the health care system to address disparities. We are excited to share this new tool, which allows us to pinpoint disparities in health care outcomes by population and condition.”

The MMD Tool was developed in collaboration with KPMG LLC and NORC at the University of Chicago as part of the [CMS Equity Plan for Improving Quality in Medicare](#). The plan provides a framework for advancing health equity by improving the quality of care provided to minority and other underserved Medicare beneficiaries.

To access the MMD tool, visit <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities.html>

To learn more about how to use the tool and its data sources, see the [MMD Tool Overview](#). Further details are available in the [MMD Tool Frequently Asked Questions \(FAQ\)](#), the [Quick Start Guide](#), and the [MMD Tool Technical Documentation](#).

*[Centers for Medicare & Medicaid Services \(CMS\) Office of Minority Health \(OMH\)](#) was established as a result of the Patient Protection and Affordable Care Act (ACA) and works to eliminate health disparities and improve the health of all minority populations, including racial and ethnic minorities, people with disabilities, members of the LGBT community, and rural populations.*

###

## **Guideline for Prescribing Opioids for Chronic Pain**

The CDC today issued new recommendations for prescribing opioid medications for chronic pain, excluding cancer, palliative, and end-of-life care.

The ‘*CDC Guideline for Prescribing Opioids for Chronic Pain, United States, 2016*’ is part of the U.S. government’s urgent response to the epidemic of overdose deaths.

The Guideline will help primary care providers ensure the safest and most effective treatment for their patients.

Click <http://www.cdc.gov/media/releases/2016/p0315-prescribing-opioids-guidelines.html> for more for details.

###

## **COMPETITIVE BIDDING PROGRAM CONTINUES TO MAINTAIN ACCESS AND QUALITY WHILE SAVING MEDICARE BILLIONS**

### **OVERVIEW**

The Centers for Medicare & Medicaid Services (CMS) today announced the new single payment amounts and began sending contract offers to successful bidders for Medicare's Round 2 Recompete and the national mail-order recompete Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. These new payment amounts and contracts go into effect on July 1, 2016. This program has been an essential tool to help Medicare set appropriate payment rates for DMEPOS items and save money for beneficiaries and taxpayers while ensuring access to quality items.

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

Under the Competitive Bidding Program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. After the first two years of Round 2 and the national mail-order programs (July 1, 2013-June 30 2015), Medicare has saved approximately \$3.6 billion while health monitoring data indicate that its implementation is going smoothly with few inquiries or complaints and no negative beneficiary health outcomes.

The Round 2 and national mail-order program contract periods expire on June 30, 2016. Round 2 Recompete and the national mail-order recompete contracts will become effective on July 1, 2016 through December 31, 2018. The national mail-order recompete for diabetes testing supplies will be implemented at the same time as Round 2 Recompete and will include all parts of the United States, including the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

### **BACKGROUND**

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

MIPPA also delayed the competition for Round 2 from 2009 to 2011 and authorized national mail-order competitions after 2010. The Affordable Care Act of 2010 (ACA) expanded the number of Round 2 MSAs from 70 to 91 and specified that all areas of the country be subject to either DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by January 1, 2016.

Competitive bidding contracts and pricing have been in place in Round 1 areas since January 1, 2011 with the current Round 1 Recompete contracts and prices being in place since January 1, 2014. CMS is currently evaluating bids received as part of the Round 1 2017 competition, which is scheduled to be implemented on January 1, 2017.

Round 2 and the national mail-order program for diabetes testing supplies was implemented on July 1, 2013. The supplier bidding period for Round 2 Recompete and the national mail-order recompete for diabetes testing supplies concluded on March 26, 2015.

## **CONTRACT AWARD PROCESS**

The DMEPOS Competitive Bidding Program's bid evaluation process ensures that there will be a sufficient number of suppliers to meet the needs of the beneficiaries living in a competitive bidding area. The new single payment amounts resulting from the competition replace the previous single payment amounts for the bid items in these areas. Small suppliers, those with gross revenues of \$3.5 million or less, make up about 56 percent of the suppliers that will be offered contracts for Round 2 Recompete. 22 percent of national mail-order contract offers are going to small suppliers. All suppliers that are offered contracts went through a thorough vetting process and are accredited and meet financial and applicable licensing standards.

CMS will now begin offering contracts to winning bidders. 12,181 contract offers will be made to 637 Round 2 Recompete bidders. Of these offers, 93 percent are to bidders who currently furnish items in the awarded area or within the product category. The winning suppliers have 2,341 locations to serve Medicare beneficiaries in the competitive bidding areas. CMS will offer 9 contracts for the national mail-order program. CMS expects to complete the contracting process in time to announce the contract suppliers in the spring of 2016. Bidders that are not offered contracts will be notified of the reasons why they did not qualify for the program when the contracting process is complete. Suppliers that are not contract suppliers for this round of the DMEPOS Competitive Bidding Program may bid in future rounds, unless they are precluded from participation in the program.

Additional information on the distribution of contract offers is available at the following Web site: [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com).

## **REAL-TIME MONITORING**

Importantly, the program has maintained beneficiary access to quality products from accredited suppliers in all competitive bidding areas. Extensive real-time monitoring data have shown successful implementation with very few beneficiary complaints and no negative impact on

beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency room visits compared to non-competitive bidding areas. In addition to our real-time claims monitoring, CMS also requested feedback from beneficiaries through consumer satisfaction surveys conducted before and after the rollout of the program. CMS provides local, on-the-ground presence in each competitive bidding area through the CMS regional offices, local liaisons, and a Competitive Acquisition Ombudsman who closely monitors and responds to inquiries and complaints about the application of the program from beneficiaries who use items of DMEPOS under the program, contract suppliers who provide these items, and other stakeholders. There is also a formal complaint process for beneficiaries, caregivers, providers and suppliers to use for reporting concerns about contract suppliers or other competitive bidding implementation issues. In addition, contract suppliers are responsible for submitting reports identifying the brands of products they furnish, which is used to inform beneficiaries, caregivers, and referral agents. CMS will continue to employ the same aggressive program monitoring for future rounds.

## **ROUND 2 RECOMPETE PRODUCT CATEGORIES AND AREAS**

The Round 2 Recompete product categories are:

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

For a list of the specific items in each product category, or for a list of the areas included in Round 2 Recompete, visit the Competitive Bidding Implementation Contractor website at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com).

## **ROUND 2 RECOMPETE AND NATIONAL MAIL-ORDER RECOMPETE TIMELINE OF EVENTS**

**March 15, 2016** CMS announces new payment rates for Round 2 Recompete and the national mail-order recompete and begins contracting process with winning suppliers

## Spring 2016

CMS announces the Medicare contract suppliers for Round 2 Recompete and the national mail-order recompete; intensifies supplier, referral agent, and beneficiary education program

## July 1, 2016

Implementation of Medicare DMEPOS Competitive Bidding Program Round 2 Recompete and national mail-order recompete contracts and prices

## ADDITIONAL INFORMATION

For additional information about the Medicare DMEPOS Competitive Bidding Program, please visit: <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/>.

###

## Social Security Announces New Online Service for Replacement Social Security Cards in Nebraska

### Available to People through a **my Social Security Account**

The Social Security Administration introduced the expansion of online services for residents of Nebraska available through its **my Social Security** portal at [www.socialsecurity.gov/myaccount](http://www.socialsecurity.gov/myaccount). Carolyn W. Colvin, Acting Commissioner of Social Security, announced that residents of Nebraska can use the portal for many replacement Social Security number (SSN) card requests. This will allow people to replace their SSN card from the comfort of their home or office, without the need to travel to a Social Security office.

"I'm thrilled about this newest online feature to the agency's **my Social Security** portal and the added convenience we are providing residents of Nebraska," Acting Commissioner Colvin said. "We continue to provide world-class customer service to the public by making it safe, fast and easy for people to do business with us online and have a positive government experience. I look forward to expanding this service option across the country."

The agency plans to conduct a gradual roll out of this service; Nebraska is one of four states, plus the District of Columbia, where this option is initially available. Throughout 2016, the agency will continue to expand the service option to other states and plans to offer this to half of the nation's population by the end of the year. This service will mean shorter wait times for the public in the more than 1,200 Social Security offices across the country and allows staff more time to work with customers who have extensive service needs.

U.S. citizens age 18 or older and who are residents of Nebraska can obtain a replacement SSN card online by creating a **my Social Security** account. In addition, they must have a U.S. domestic mailing address, not require a change to their record (such as a name change), and have a valid driver's license, or state identification card in some participating states.

**my Social Security** is a secure online hub for doing business with Social Security, and more than 22 million people have created an account. In addition to Nebraska residents replacing their SSN card through the portal, current Social Security beneficiaries can manage their account—

change an address, adjust direct deposit, obtain a benefit verification letter, or request a replacement SSA-1099. Medicare beneficiaries can request a replacement Medicare card without waiting for a replacement form in the mail. Account holders still in the workforce can verify their earnings and obtain estimates of future benefits.

For more information about this new online service, visit [www.socialsecurity.gov/ssnumber](http://www.socialsecurity.gov/ssnumber).

###

## Social Security Announces New Online Service for Replacement Social Security Cards in Iowa

### Available to People through a my Social Security Account

The Social Security Administration introduced the expansion of online services for residents of Iowa available through its my Social Security portal at [www.socialsecurity.gov/myaccount](http://www.socialsecurity.gov/myaccount). Carolyn W. Colvin, Acting Commissioner of Social Security, announced that residents of Iowa can use the portal for many replacement Social Security number (SSN) card requests. This will allow people to replace their SSN card from the comfort of their home or office, without the need to travel to a Social Security office.

"I'm thrilled about this newest online feature to the agency's my Social Security portal and the added convenience we are providing residents of Iowa," Acting Commissioner Colvin said. "We continue to provide world-class customer service to the public by making it safe, fast and easy for people to do business with us online and have a positive government experience. I look forward to expanding this service option across the country."

The agency plans to conduct a gradual roll out of this service; Iowa is one of six states, plus the District of Columbia, where this option is initially available. Throughout 2016, the agency will continue to expand the service option to other states and plans to offer this to half of the nation's population by the end of the year. This service will mean shorter wait times for the public in the more than 1,200 Social Security offices across the country and allows staff more time to work with customers who have extensive service needs.

U.S. citizens age 18 or older and who are residents of Iowa can obtain a replacement SSN card online by creating a my Social Security account. In addition, they must have a U.S. domestic mailing address, not require a change to their record (such as a name change), and have a valid driver's license, or state identification card in some participating states.

my Social Security is a secure online hub for doing business with Social Security, and more than 23 million people have created an account. In addition to Iowa residents replacing their SSN card through the portal, current Social Security beneficiaries can manage their account—change an address, adjust direct deposit, obtain a benefit verification letter, or request a replacement SSA-1099. Medicare beneficiaries can request a replacement Medicare card without waiting for a replacement form in the mail. Account holders still in the workforce can verify their earnings and obtain estimates of future benefits.

For more information about this new online service, visit [www.socialsecurity.gov/ssnumber](http://www.socialsecurity.gov/ssnumber).

###

## **Social Security Number Removal Initiative (SSNRI) content for CMS web page**

The Centers for Medicare & Medicaid Services (CMS) posted information to ensure that agency partners have access to basic information about the Social Security Number Removal Initiative (SSNRI), created to meet the requirements and timeline included in MACRA. CMS is still in a reactive communications mode on this initiative and to get ready for the new Medicare cards.

For additional information, click here:

<https://www.cms.gov/Outreach-and-Education/Look-Up-Topics/Medicare/SSNRI-Message.html>

###

## **CMS finalizes mental health and substance use disorder parity rule for Medicaid and CHIP**

*Final rule strengthens access to mental health and substance use disorder benefits for low-income Americans*

In conjunction with the President's visit to the National Rx Drug Abuse and Heroin Summit, the Centers for Medicare & Medicaid Services (CMS) today finalized a rule to strengthen access to mental health and substance use services for people with Medicaid or Children's Health Insurance Program (CHIP) coverage, aligning with protections already required of private health plans. The Mental Health Parity and Addiction Equity Act of 2008 generally requires that health insurance plans treat mental health and substance use disorder benefits on equal footing as medical and surgical benefits.

"The Affordable Care Act provided one of the largest expansions of mental health and substance use disorder coverage in a generation," HHS Secretary Sylvia M. Burwell said. "Today's rule eliminates a barrier to coverage for the millions of Americans who for too long faced a system that treated behavioral health as an unequal priority. It represents a critical step in our effort to ensure that everyone has access to the care they need.

"This rule will also increase access to evidence-based treatment to help more people get the help they need for their recovery and is critical in our comprehensive approach to addressing the serious opioid epidemic facing our nation."

"The need to strengthen access to mental health and substance use disorder services is clear," said Vikki Wachino, Deputy Administrator of CMS and Director of the Center for Medicaid and CHIP Services. "This final rule will help states strengthen care delivery and support low-income individuals in accessing the services and treatment they need to be healthy."

The protections set forth in this final rule will benefit the over 23 million people enrolled in Medicaid managed care organizations (MCOs), Medicaid alternative benefit plans (ABPs), and CHIP. Currently, states have flexibility to provide services through a managed care delivery mechanism using entities other than Medicaid managed care organizations, such as prepaid inpatient health plans or prepaid ambulatory health plans. The final rule maintains state flexibility

in this area while guaranteeing that Medicaid enrollees are able to access these important mental health and substance use services in the same manner as medical benefits.

Under the final rule, plans must disclose information on mental health and substance use disorder benefits upon request, including the criteria for determinations of medical necessity. The final rule also requires the state to disclose the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

This is one of our latest efforts to increase access to and improve mental health services and care for low income individuals, especially in light of the opioid abuse epidemic, which constitute significant health risks and cost drivers in the Medicaid program. We introduced several initiatives to assist states with behavioral health system transformation to better meet the needs of beneficiaries with substance use disorders:

- In 2014, CMS launched the Innovation Accelerator Program, a new strategic and technical support platform designed to improve delivery systems for beneficiaries that are high need and high cost. Our first effort in this area was to provide states with expert resources, coaching opportunities and individualized technical assistance to accelerate policy, program and payment reforms appropriate for a robust substance use disorder delivery system.
- In July 2015, CMS issued guidance to states on a new section 1115 demonstration opportunity to develop a full continuum of care for beneficiaries with a substance use disorder, including coverage for short-term residential treatment services not otherwise covered by Medicaid.
- In response to the growing prescription opioid abuse epidemic, CMS recently released information on effective safeguards and options to help address over-prescribing of opioid pain medications.
- CMS disseminated important information regarding screening and early intervention services for children and youth who have or may have a mental illness or substance use disorder, including best practice information for the delivery of medication-assisted treatment as well as services and supports that can address first psychiatric episodes to reduce the likelihood of ongoing hospitalizations, involvement with police and courts, and increase the chances of keeping families intact.

The final rule is currently on display at <https://www.federalregister.gov/public-inspection> and will be published in the Federal Register on March 30, 2016.

For more information, go to <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html>.

###

## Medicaid Expansion Can Improve Behavioral Health Care Access

The U.S. Department of Health and Human Services released a report showing that states can greatly improve access to behavioral health services for residents by expanding Medicaid under the Affordable Care Act.

"Today's report shows that Medicaid expansion is an important step states can take to address behavioral health needs, including serious mental illness and opioid and other substance use disorders," said Secretary Sylvia M. Burwell.

To read today's **press release**, visit: <http://www.hhs.gov/about/news/2016/03/28/new-report-shows-medicaid-expansion-can-improve-behavioral-health-care-access.html>

To read today's **report**, visit: <https://aspe.hhs.gov/pdf-report/benefits-medicaid-expansion-behavioral-health>

###

## Medicaid Enrollment and Expenditure Data Collected through Medicaid Budget and Expenditure System (MBES)

The Centers for Medicare & Medicaid Services (CMS) released updated Medicaid enrollment data and preliminary expenditure data that states reported to CMS through the Medicaid Budget and Expenditure System (MBES). The [enrollment information](#) is a state-reported count of unduplicated individuals enrolled in the state's Medicaid program at any time during each month in the quarterly reporting period and includes new enrollment data from July 1, 2015 – September 30, 2015. The enrollment data identifies the total number of Medicaid enrollees and, for states that have expanded Medicaid, provides specific counts for the number of individuals enrolled in the new adult eligibility group, also referred to as the "VIII Group". In addition to the new information presented in today's report, the posting includes updated enrollment data for the period October 1, 2014 – June 30, 2015.

The preliminary [expenditure data](#) provides summary level data associated with Medicaid service expenditures reported by states on the Form CMS-64 in MBES for the period January 1, 2015 – March 31, 2015. The data includes a breakout of expenditures associated with individuals in the VIII Group. In addition to the new information presented in today's report, the posting includes updated expenditure data for the period January 1, 2014 – December 31, 2014.

### **Helpful weblinks:**

Medicaid Enrollment Data Collected through MBES located at:

<https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes.html>

Expenditure Reports from MBES/CBES located at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html>

## **CMS Launches New Effort to Improve care for Nursing Facility Residents**

*New payment model test for nursing facility care aims to reduce avoidable hospitalizations*

The Centers for Medicare & Medicaid Services (CMS) today announced it will test whether a new payment model for nursing facilities and practitioners will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents.

This next phase of the *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents* seeks to reduce avoidable hospitalizations among beneficiaries eligible for Medicare and/or Medicaid by providing new payments to practitioners for engagement in multidisciplinary care planning activities. In addition, the participating skilled nursing facilities will receive payment to provide additional treatment for common medical conditions that often lead to avoidable hospitalizations.

Through this model, CMS would facilitate practitioner engagement when a nursing facility resident needs higher-intensity interventions due to an acute change in condition. Medicare currently pays physicians less for a comprehensive assessment at a skilled nursing facility than for the same assessment at a hospital. This model would equalize the payments between the sites of care. Removing potential barriers to effective treatment within a facility can improve the residents' care experience and mitigate the need for disruptive and costly hospitalizations. For example, participating skilled nursing facilities will be expected to enhance their staff training and purchase new equipment to improve their capacity to provide intravenous therapy and cardiac monitoring.

"This Initiative has the potential to improve the care for the most frail, most vulnerable Medicare-Medicaid enrollees—long-stay residents of nursing facilities," said Tim Engelhardt, Director of the Medicare-Medicaid Coordination Office. "Smarter spending can improve the quality of on-site care in nursing facilities and the assessment and management of conditions that too often now lead to unnecessary and costly hospitalizations."

Since 2012, CMS has funded Enhanced Care and Coordination Providers (ECCPs) to test a model to improve care for long-stay nursing facility residents through clinical and educational interventions. The ECCPs currently collaborate with 143 long-term care facilities to provide on-site staff for training and preventive services and to improve the assessment and management of medical conditions. Early results from the first phase of the Initiative are promising, according to an [independent evaluation](#). All seven sites generally showed a decline in all-cause hospitalizations and potentially avoidable hospitalizations, with four sites showing statistically significant reductions in at least one of the hospitalization measures. In addition, all sites generally showed reductions in Medicare expenditures relative to a comparison group in 2014, with statistically significant declines in total Medicare expenditures at two sites. This first phase of the Initiative will continue through 2016.

This new four-year payment phase of the Initiative, slated to begin fall 2016, will be implemented through cooperative agreements with six ECCPs. The six awardees are:

- Alabama Quality Assurance Foundation – Alabama
- HealthInsight of Nevada – Nevada and Colorado

- Indiana University – Indiana
- The Curators of the University of Missouri – Missouri
- The Greater New York Hospital Foundation, Inc. – New York
- UPMC Community Provider Services – Pennsylvania

The new model will be subject to a rigorous independent evaluation to determine the effects on cost and quality of care. ECCP awardees will implement the payment model with both their existing partner facilities, where they provide training and clinical interventions, and in a comparable number of additional facilities to be recruited over the next several months.

The Initiative is a collaboration of the CMS Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation, both created by the Affordable Care Act to test payment models to improve health care quality and reduce costs in the Medicare and Medicaid programs. The Initiative complements broader administration efforts to improve long-term care facilities, including proposed updates to the conditions of participation for nursing homes, improvements to the five-star rating system for consumers, and implementation of the new Skilled Nursing Facility Quality Reporting Program that ties skilled nursing facility payment to the reporting of quality measures.

For more information on this Initiative, including both current activities and this new phase, please visit: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/AvoidableHospitalizationsamongNursingFacilityResidents.html>

###

## **FRAUD ADVISORY: Inspector General Warns Public About "Disability Services" Phone Calls**

Social Security Inspector General Patrick P. O'Carroll is warning citizens to be aware of phone calls from unknown people who claim to have information about a citizen's application for disability benefits and offer assistance with the citizen's claim. The Office of the Inspector General (OIG) received a report from a Maryland citizen who recently received several of these phone calls, even though the citizen had not applied for disability benefits.

The callers appear to be "phishing" for personal information—such as Social Security numbers or personal financial information—from unknowing citizens, who possibly have applied for disability benefits and thus might be inclined to provide information to the caller in furtherance of his or her claim. One person, who had not applied for disability benefits, reported recently receiving three unsolicited calls from a caller named Scott from a phone number with a 301 area code.

There are several variations of this type of phone phishing scam, which could lead to identity theft and/or government benefit theft. The Internal Revenue Service (IRS) recently warned of [similar phone calls from people impersonating IRS agents](#) who request information to process a citizen's tax return.

Therefore, Inspector General O'Carroll urges you to remain vigilant and protect your personal information. O'Carroll states, "You should never provide your Social Security number, bank account numbers, or other personal information by telephone or over the Internet unless you are extremely confident of the source to which you are providing the information."

If you have questions about any communication—phone call, email, letter, or text—that claims to be from or have a connection to the Social Security Administration, O'Carroll recommends you contact your local Social Security office, or call Social Security's toll-free customer service number at **1-800-772-1213**, 7 a.m. to 7 p.m., Monday through Friday, to verify its legitimacy. (Those who are deaf or hard-of-hearing can call Social Security's TTY number at 1-800-325-0778.)

You may report suspicious activity or communications involving Social Security programs and operations to the Social Security Fraud Hotline at <https://oig.ssa.gov/report>, or by phone at 1-800-269-0271, 10 a.m. to 4 p.m., Eastern Standard Time, Monday through Friday. (Those who are deaf or hard-of-hearing can call the OIG TTY number at 1-866-501-2101.)

###

## **CMS Invites Quality Innovation Network-Quality Improvement Organizations to Submit Special Innovation Projects to Expand Their Reach in Improving Care Delivery**

The Centers for Medicare & Medicaid Services' (CMS) Quality Improvement Organization (QIO) Program is constantly evolving to help ensure that Medicare beneficiaries receive better care, better health, and greater value. Today, CMS is announcing the program's next evolution: two projects focused on supporting and scaling quality improvement innovations.

With this announcement, Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) can collaborate with health care providers and/or partners to compete for 28 Special Innovation Project (SIP) awards that fall within two topic categories totaling \$8 million. Statements of Objectives will be released in early April to the QIO community. Information regarding award dates will be included in the Statement of Objectives.

SIPs are two-year quality improvement projects that align with the goals of the [CMS Quality Strategy](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html) (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>) and emphasize the power of partnerships. There are two categories of SIPs for QIN-QIOs to consider:

1. "Innovations that Advance Local Efforts for Better Care and Smarter Spending," which will address healthcare quality issues that occur within specific QIN-QIO regions.
2. "Interventions that are Ripe for Spread and Scalability," which will focus on expanding the scope and national impact of a quality improvement project that has experienced proven but limited success. The expectation is that similar benefits would be experienced on a large scale if spread throughout the greater health care community.

The scalability category aligns with the CMS [Strategic Innovation Engine](http://sie.qioprogram.org/) (SIE) (<http://sie.qioprogram.org/>), a new endeavor launched in August of 2015. The SIE is working to rapidly move innovative, evidence-based quality practices from research to implementation

through the QIO Program. In consultation with the SIE Executive Leadership Council, CMS is seeking projects that:

Streamline patient flow in various health care settings, including hospital units, outpatient clinics, primary care offices, ambulatory surgical centers, and cancer centers resulting in efficiencies, improved satisfaction, decreased mortality, better care, healthier people, and smarter spending.

- Work with health plans and/or care coordination providers to deploy an integrated approach to post-acute care that results in enhanced care management, safe transitions from one care setting to another, improved health outcomes, and reductions in harms.
- Increase value, patient affordability, and appropriate use of specialty drugs by applying evidenced based criteria to prescribing practices and by monitoring effectiveness when providers have a choice(s) among equally effective drugs with differing costs.
- Address acute pain management. For example, more is needed to assist sickle cell patients: from accurate identification of their illness to education of emergency department staff on sickle cell disease while addressing the cultural stigmas often associated with the disease.
- Utilize big data analytics to reduce preventable harm in healthcare.

We encourage those in the larger healthcare community who are leading quality work in these areas, with interventions and proven results, to reach out and explore potential partnerships with QIN-QIOs. Through collaboration with healthcare providers, patients, families, and other key stakeholders, QIN-QIOs have tremendous potential to take those interventions to the national level and improve the health care delivery system by tapping into new settings of care and building upon the knowledge gained by people working on the front line of providing quality health care.

The QIN-QIOs selected to carry out these SIPs will leverage their data-driven approach, extensive partnerships, and the voices of patients and families to positively impact Medicare beneficiaries in their communities and nationwide.

The QIO Program's 14 QIN-QIOs work with providers, community partners and beneficiaries on multiple data-driven quality improvement initiatives to improve patient safety, reduce harm, engage patients and families, improve clinical care and reduce healthcare disparities. For more information about the CMS QIO Program and for a complete list of QIN-QIOs, please visit the QIO Program [website \(http://www.qioprogram.org/\)](http://www.qioprogram.org/).

###

## Upcoming Webinars and Events

### Marketplace Webinar Invitation – Friday, April 1 from 1:00 PM ET to 2:00 PM Central

Please join us for our bi-weekly assister webinar, where we will share important Marketplace updates, including updates to our *From Coverage to Care* post-open enrollment planning, and two presentations. We still have a few weeks left in tax season, so for our first presentation we will be joined by a guest from the Internal Revenue Service who will discuss the healthcare-related IRS tax provisions affecting individual income tax filers. In particular, the presentation will cover the Premium Tax Credit, including how to file/claim it and reconcile advance payments. We will also discuss the Individual Shared Responsibility Provision, including the differences between IRS and Marketplace exemptions. We will also provide an updated presentation from our Complex Case Scenario series on how to help consumers evaluate their offer of employer-sponsored coverage.

#### What:

1. Marketplace Updates
2. Healthcare-related Tax Provisions affecting Individuals and Families
3. Complex Case: Evaluating Employer-Sponsored Coverage

#### Who Should Attend:

Navigators, enrollment assistance personnel, and certified application counselors (CACs)

#### When:

Friday, April 1 from 1:00 PM to 2:00 PM Central

#### RSVP:

To facilitate a quicker registration process on the day of the event, please register for the session by visiting the following link: <https://goto.webcasts.com/starthere.jsp?ei=1097416>.

**Space is limited – we strongly encourage individuals from the same organization to gather in a common room and participate as a group using a single computer or call-in line.**

The audio portion of the webinar will be delivered via your computer. Please check your computer settings in advance to ensure that your speaker volume is adjusted appropriately. If you cannot hear audio through your computer speakers, please refer to the Alternate Audio tab on the left side of the webinar screen.

Please try to log in 5 minutes in advance so that audio links can be made.

###

## **CMS National Training Program - Marketplace 101 Webinar**

**April 7, 2016 12:00 – 1:30 pm Central**

This webinar provides a high-level overview of the Affordable Care Act and the Health Insurance Marketplace, including information on coverage, tax credits, and fees.

**Webinar:** <https://goto.webcasts.com/starthere.jsp?ei=1093375>

###

## **Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Register Now**

Tuesday, April 5 from 12:30 to 2 pm Central

To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this call, CMS subject matter experts provide information on what you can do to prepare for the Medicare Shared Savings Program (Shared Savings Program) application process for the January 1, 2017, program start date. A question and answer session will follow the presentation.

We encourage call participants to review important information, dates, and materials on the [Shared Savings Program Application](#) webpage prior to the call.

Agenda:

- Introduction to the Shared Savings Program
- What is an Accountable Care Organization (ACO)?
- ACO organizational structure and governance
- ACO governing body template
- Skilled Nursing Facility (SNF) 3-day waiver application information
- Antitrust and ACOs
- Application process for January 2017 starters

Target Audience: Potential 2017 Shared Savings Program initial applicants.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) webpage to learn more.

###

## **Medicare Shared Savings Program ACO Application Process Call — Register Now**

Tuesday, April 19 from 12:30 to 2 pm Central

To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this call, CMS subject matter experts cover helpful tips to complete a successful application for the Medicare Shared Savings Program (Shared Savings Program). A question and answer session will follow the presentation.

We encourage call participants to review important information, dates, and materials on the [Shared Savings Program Application](#) webpage prior to the call.

Agenda:

- Accountable Care Organization (ACO) participant list and participant agreements
- ACO Skilled Nursing Facility (SNF) affiliate list and SNF affiliate agreements (Track 3 ACOs only)
- Beneficiary assignment

Target Audience: Potential 2017 Shared Savings Program initial applicants.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) webpage to learn more.

###

### **Care Act: Employer Shared Responsibility Provision (IRC 4980H)**

**When:** April 6, 2016; 1 p.m. Central

**How:** Register [here](#) for this webinar

**Learn about:**

- How to determine if you are considered an applicable large employer
- What is the definition of a full-time employee?
- Learn the filing requirements and transition relief for 2015

###

### **Managed Care and Homeless Populations: Linking the HCH Community and MCO Partners**

**Presented by UnitedHealthcare and the National Health Care for the Homeless Council**

**Tuesday, April 5, 2016 | 12:30-1:30 p.m. Central**

In states that expanded Medicaid, many people experiencing homelessness became eligible for health insurance, often enrolling in a Medicaid plan offered through a managed care organization (MCO). This development means that there are new opportunities for managed care plans and health care providers to work together to improve health outcomes in a patient population that tends to have intensive needs and high service utilization. Together with a [new policy brief](#), this webinar will offer homeless health care providers an overview of managed care, as well as familiarize MCO plans with the needs of people who are homeless and the model of care employed by Health Care for the Homeless (HCH) projects.

Discussion will focus on how both groups can better achieve common goals through strong partnerships and open communication. Leaders from two HCH projects and an MCO plan in Washington State will describe their work surrounding medical respite\* services, how their collaborations originated, and early lessons from their journey to improve outcomes. Join us for a discussion intended to establish more common understanding between insurers and providers—two key stakeholder groups directly involved in the provision of health care for people experiencing homelessness.

**Panelists:**

- **Catherine Anderson**, Vice President, Positioning and Strategy, UnitedHealthcare Community & State
- **Barbara DiPietro**, Senior Director of Policy, National HCH Council
- **Doug Bowes**, CEO, UnitedHealthcare Community Plan of Washington
- **Edward Dwyer-O'Connor**, BS, RN, Senior Manager, Downtown Programs, Harborview Medical Center, Seattle, WA
- **Matt Lund**, Director of Contracting, UW Medicine at Harborview Medical Center, Seattle, WA
- **Rhonda Hauff**, COO/Deputy CEO, Yakima Neighborhood Health, Yakima, WA

**Learning Objectives:**

1. Understand the factors influencing Medicaid managed care plans, their approach to serving people experiencing homelessness, and how they are seeking opportunities to partner with providers serving the population.
2. Understand how the HCH Community can maximize common goals with managed care plans.
3. Describe how two HCH projects in Washington State (one urban and one rural) are partnering with a managed care plan for medical respite services.

###



## April Educational Webinars

- [Battling the Nursing Shortage in Rural Communities](#)
- [Using an Intranet and Policy Management Solutions to be CMS Survey Ready](#)
- [Lessons Learned from the Unprecedented HIV Outbreak in Southern Indiana](#)
- [Increase Revenue in Your Sleep](#)
- [How Rural Healthcare Organizations Can Implement Meaningful Executive Compensation Processes](#)

### **How can you overcome the nursing shortage?**

When nursing education is not accessible or is not meeting current nurse staffing demands for healthcare providers, a nursing shortage occurs that negatively impacts the quality of healthcare provided to the community. Nightingale College is bringing quality nursing education to rural communities and elevating the quality of healthcare provided.

#### **Attend a free webinar to:**

- Understand the Nursing Shortage Cycle
- Recognize the outcomes associated with the nursing shortage
- Uncover how to grow your own nurses in house and gain access to a higher education nursing program

### **[Battling the Nursing Shortage in Rural Communities](#)**

**Date:** Tuesday, April 5

**Time:** 2:00 - 3:00 PM Central Time

**Cost:** Free

**Target Audience:** Chief Executive Officer, Chief Nursing Officer, Director of Nursing, Human Resources Director, and managers

#### **Presenters**

**Jonathan Tanner**

Vice President

Nightingale College

**KayLa Webster**

DDC Coordinator  
Nightingale College

**Jill McCullough**

DDC Coordinator  
Nightingale College

**[REGISTER TODAY](#)**

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If you feel another department would benefit from this educational webinar please forward to the appropriate department. You can find other on-demand webinars [here](#).

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**Are you compliant and CMS survey ready?**

What types of information should you be monitoring and tracking to stay compliant? How can you prepare and train your staff? What tools can you use to help your organization develop an effective CMS compliance program? A huge part of staying compliant is having the right technology in place to keep you risk-free. We will share best practices of an effective CMS compliance program, key success tips for CMS compliance, and compliance automation so your organization can perform a self-audit at a moment's notice.

**Attend a free webinar to:**

- Learn key information for CMS compliance
- Discover tips for an effective compliance program
- Address challenges with CMS compliance
- Find out how technology can assist with compliance

**[Using an Intranet and Policy Management Solutions to be CMS Survey Ready?](#)**

**Date:** Wednesday, April 6

**Time:** 2:00 - 3:00 PM Central Time

**Cost:** Free

**Target Audience:** Chief Executive Officer, Chief Nursing Officer, Director of Nursing, Human Resources Director, Chief Medical Officer, Chief Technical Officer, Chief Information Officer, Director of Clinical Quality, Risk Management, Risk Analysts, Compliance Analyst/Auditor/Officer, Regulatory Affairs personnel, Medical Claims Specialist, and managers

**Presenter**

**Albert Jurkiewicz**

Policy and Procedure Implementation Expert

Lead Architect

**REGISTER TODAY**

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If you feel another department would benefit from this educational webinar please forward to the appropriate department. You can find other on-demand webinars [here](#).

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**What steps can clinicians take to prevent HIV transmission and optimize HIV care in rural communities?**

Southern Indiana has experienced an unprecedented outbreak of HIV infection over the past year, driven largely by an epidemic of injection drug use in rural America. Primary care clinicians, mental health professionals, and addiction specialists in this region have an essential role to play in preventing new HIV transmissions among individuals at high risk and providing HIV medical care to those who have been newly diagnosed.

**Attend a free webinar to:**

- Explore best practices and challenges in the prevention, testing, and treatment of HIV, HCV and STIs in areas with a high prevalence of opioid-use disorder

- Explain the rationale for and the details of screening HIV, HCV and STIs for people who inject drugs.

### [Lessons Learned from the Unprecedented HIV Outbreak in Southern Indiana](#)

**Date:** Tuesday, April 12

**Time:** 2:00 - 3:00 PM Central Time

**Cost:** Free

**Target Audience:** Primary care clinicians (physicians, nurses, NPs, PAs), mental health professionals, addiction specialists, and other clinicians interested in preventing or managing HIV

#### **Presenters**

##### **Diane Janowicz, MD**

Medical Director for MATEC-IN

Assistant Professor of Clinical Medicine

Indiana University School of Medicine

Fellowship Program Director-Infectious Diseases

Indianapolis, IN

##### **Matthew Miles, MD**

Internal Medicine Chief Resident, Safety and Quality Improvement

Indiana University Internal Medicine Residency Program

Indianapolis, IN

### [REGISTER TODAY](#)

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If you feel another department would benefit from this educational webinar please forward to the appropriate department. You can find other on-demand webinars [here](#).

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### **How can rural hospitals boost their revenue and pave the way for innovation?**

Rural hospitals continue to face competition from larger systems and have to overcome the perception that they lack innovation and services. However, as a rural hospital there

are still ample opportunities to build revenue, develop new service lines, and increase patient volume.

**Attend a free webinar to:**

- Learn how to establish partnerships and relationships to pave the way for innovation and an increase in services at rural hospitals.
- Discuss how to build the relationships needed to boost revenue, patient volumes, and increase the number of service lines.

**[Increase Revenue in Your Sleep](#)**

**Date:** Tuesday, April 19

**Time:** 2:00 - 3:00 PM Central Time

**Cost:** Free

**Target Audience:** Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, Medical Group Managers, Service Line Directors, and Marketing Managers

**Presenters**

**Gayla Beaird**

Respiratory Therapy Director

Howard Memorial Hospital

**John Ostrander**

Owner

Vertex Sleep Solutions

**[REGISTER TODAY](#)**

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If you feel another department would benefit from this educational webinar please forward to the appropriate department. You can find other on-demand webinars [here](#).

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**Learn to develop and implement an executive compensation process that will withstand intense scrutiny.**

Executive Compensation continues to take on increased visibility due to Form 990, heightened media and government scrutiny. Rural healthcare organizations such as CAHs and the PPS facilities must be compliant while navigating base salary measurements and meeting budgetary goals.

**Attend a free webinar to:**

- Explore best practices for developing and implementing an executive compensation process that will withstand intense scrutiny.

**[How Rural Healthcare Organizations Can Implement Meaningful Executive Compensation Processes](#)**

**Date:** Wednesday, April 27

**Time:** 2:00 - 3:00 PM Central Time

**Cost:** Free

**Target Audience:** Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, Human Resources Director, and Chief Nursing Officer

**Presenter**

**Larry Unroe**

CEO of Memorial Health System, *retired*

**[REGISTER TODAY](#)**

###

**Agent and Broker Tips for Assisting in the Small Business Health Options Program (SHOP) Marketplaces**

CMS will be hosting a webinar, "Agent and Broker Tips for Assisting in the Small Business Health Options Program (SHOP) Marketplaces," on Wednesday, April 20 from 1:00 PM to 2:30 PM Eastern Time.

CMS subject matter experts will provide tips for agents and brokers on how they can use the SHOP Marketplace effectively, including:

- The benefits of the SHOP Marketplace for agents and brokers
- How to access training on the SHOP Marketplace Agent/Broker Portal
- A review of the SHOP Marketplace employer and employee applications

To register for the webinar, please log in to [www.REGTAP.info](http://www.REGTAP.info). If you have questions on the webinar registration process, visit the “Upcoming Agent and Broker Webinars” section of the [Agents and Brokers Resources webpage](#) for more information.

###

## **What Did We Learn From the Affordable Care Act's Third Open Enrollment Period? Recorded Webinar from Enroll America**

- Webinar slides can be found here: <https://www.enrollamerica.org/research-maps/webinars/what-did-we-learn-from-the-affordable-care-acts-third-open-enrollment-period/>
- Information on the Get Covered Academy can be found here: <https://www.enrollamerica.org/get-covered-america/get-covered-academy/>
- Information on the Get Covered Connector can be found here: <https://www.enrollamerica.org/get-covered-america/get-covered-connector/>
- Information on the Get Covered Plan Explorer can be found here: <https://www.enrollamerica.org/get-covered-america/get-covered-plan-explorer/>

### **What does the future hold for Affordable Care Act outreach and enrollment?**

- **The most important takeaways from OE3.**
- **Updates from Enroll America staff about the on-the-ground, online, and coalition-driven strategies that have been proven to increase enrollment.**
- **And insights from data on how to reach consumers as effectively as possible.**

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### **[Watch: What People Need to Know If They Face a Data Matching Issue](#)**

Millions of Americans have benefited from the new coverage provisions made available by the Affordable Care Act, and at the end of the third open enrollment period for marketplace coverage, about 12.7 million individuals had enrolled.

To ensure that individuals keep their new coverage, Enroll America hosted a webinar moderated by SpeakHispanic and in partnership with the Center on Budget and Policy Priorities and the

Centers for Medicare and Medicaid Services to walk through the steps people need to take if they received a notice from the marketplace about a “data matching issue.”

Click on the link above to watch the recording for an overview of why people might face data matching issues, and what steps they need to take if they do.

###

## **Taxes and the Health Insurance Marketplace**

**April 5 at 12:00 pm Central**

### **To RSVP and attend**

The 2016 tax season is upon us and individuals and families will be asked for some basic information regarding their health coverage on their tax returns. Learn what consumers need to know when filing their taxes, the importance of Form 1095-A and the penalty for not having health insurance. Guest speakers working on the ACA and taxes will present as well.

###

### ***Health Reform: Beyond the Basics* webinar presented in partnership with the National Health Law Program that provided information on marketplace appeals.**

It detailed what decisions can be appealed, how to file an appeal, and ways to expedite the appeal process.

If you were not able to join us or would like to review the webinar, **the presentation is now available for viewing** at [www.healthreformbeyondthebasics.org](http://www.healthreformbeyondthebasics.org). Please see below for materials and resources from the webinar:

↓ [Download the slide deck PDF](#)

[View webinar](#)

To view video recordings of past *Health Reform: Beyond the Basics* webinars and to access additional resources, please visit [Health Reform: Beyond the Basics](#).

If you have any questions, please don't hesitate to contact us!

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If you wish to unsubscribe from future CMS Region 7 emailings, please send an email to Lorelei Schieferdecker at [Lorelei.Schieferdecker@cms.hhs.gov](mailto:Lorelei.Schieferdecker@cms.hhs.gov) with the word “Unsubscribe” in the subject line.