

CMS Region 7 Updates

03/11/2016

Marketplace Updates

SPECIAL ENROLLMENT CONFIRMATION PROCESS

Special enrollment periods (SEPs) are an important way to make sure that people who lose health insurance during the year or who experience major life changes like getting married or having a child have the opportunity to enroll in coverage through the Health Insurance Marketplaces outside of the annual Open Enrollment period. SEPs are a longstanding feature of employer insurance, and without them many people would lack options to maintain continuous coverage. But it's equally important to avoid SEPs being misused or abused.

At CMS, we are always monitoring the health and operations of the Marketplace and looking for ways to improve. We are focused on continually maintaining and refining a set of Marketplace rules that create a healthy, stable and balanced risk pool. Concerns have been recently raised about whether current Marketplace rules and procedures are sufficient to ensure that only those who are eligible enroll through SEPs. In response to that feedback, today we are announcing a new Special Enrollment Confirmation Process that will address these concerns in the 38 states using the HealthCare.gov platform. These changes will enhance program integrity and contribute to a stable rate environment and affordability for consumers.

Once the new Special Enrollment Confirmation Process is implemented, all consumers enrolling through the most common HealthCare.gov SEPs will need to submit documentation to verify their eligibility to use an SEP. The Special Enrollment Confirmation Process will be accompanied by other improvements to the SEP application process, described below. Today's announcement represents a major overhaul of the SEP process.

Over the next few weeks, CMS will invite comment from consumer advocates, insurance companies and other stakeholders on the key features of the new Special Enrollment Confirmation Process, such as communication with consumers, acceptable documentation, and refining and targeting the verification process. These comments will help inform implementation of the new process. This announcement builds on action CMS has taken to eliminate unnecessary SEPs and clarify the rules for other SEPs.

How Special Enrollment Confirmation Works

Document Submission by Consumers: Beginning in the next several months, all consumers who enroll or change plans using an SEP for any of the following triggering events will be directed to provide documentation:

- Loss of minimum essential coverage,
- Permanent move,
- Birth,
- Adoption, placement for adoption, placement for foster care or child support or other court order, or
- Marriage.

These SEPs represented three quarters of HealthCare.gov consumers who enrolled or changed plans using an SEP in the second half of 2015.

We will provide consumers with lists of qualifying documents, like a birth or marriage certificate. Consumers will be able to upload documents to their HealthCare.gov account or mail them in.

Document Verification by CMS: CMS will institute a verification process for consumers who enroll or change plans using an SEP in 2016. The Special Enrollment Confirmation Process is modeled after approaches used by the Internal Revenue Service. We will review documents to ensure consumers qualify for an SEP and will follow up with consumers if there is a question or problem. Consumers need to be sure to provide sufficient documentation. If they don't respond to our notices, they could be found ineligible for their SEP and could lose their insurance.

Implementing The Special Enrollment Confirmation Process

As we move forward with implementing the Special Enrollment Confirmation Process, CMS intends to work closely with our enrollment partners. In particular, we invite feedback on:

- **Communicating with consumers about providing required documents:** As CMS implements the Special Enrollment Confirmation Process, we will work closely with enrollment partners to ensure our notice language is clear about what documents a consumer should submit and how those documents can be submitted. We also invite feedback on best practices for communicating with consumers regarding what documents can be used to establish eligibility for different SEPs.
- **Refining the confirmation process:** We invite feedback on how our verification efforts respond to areas where there is the greatest risk of SEP misuse.
- **Training assisters, agents and brokers:** CMS will develop resource guides for advocates, assisters, agents and brokers to help them understand the Confirmation Process, acceptable documents, and situations in which consumers do and don't qualify for SEPs.

Feedback on the Special Enrollment Confirmation Process should be sent to SEP@cms.hhs.gov.

What Else CMS Is Doing To Improve Program Integrity For Special Enrollment Periods

Requiring consumers to acknowledge document request and reminding consumers of the need to be truthful: In the next few weeks, HealthCare.gov will require all consumers who enroll or

change plans through an SEP to indicate they understand that documents will be requested to verify their SEP eligibility. This process will begin in the coming weeks and will ramp up over time and continue expanding once the Special Enrollment Confirmation Process is fully in place. Consumers must also attest at the end of their HealthCare.gov application that they are providing true information and understand the penalties for misrepresentation. We'll be updating the application to include additional attestation language so that consumers understand that they are required to be truthful and risk losing their eligibility for Marketplace coverage.

Clarifying application questions for consumers: In the coming weeks, we'll be updating HealthCare.gov to make it clearer for consumers who are submitting or updating an application to understand what does and doesn't qualify as a loss of minimum essential coverage, and a permanent move.

Call 1-800-318-2596 to report Fraud or abuse: Anyone who suspects that there has been fraud or abuse in the Marketplace should call 1-800-318-2596 to report their concerns. Simply indicate that you are calling about fraud and abuse and CMS investigators will receive the complaint.

###

NEW SPECIAL ENROLLMENT CONFIRMATION PROCESS ANNOUNCED

On February 24, 2016, CMS announced a new [Special Enrollment Confirmation Process](#).

Under the new Special Enrollment Confirmation Process all consumers applying through the most common HealthCare.gov Special Enrollment Periods (SEPs) will be directed to submit documentation to verify their eligibility to use a SEP. CMS will then review the documents to ensure consumers qualify for a SEP. The Special Enrollment Confirmation Process will be implemented over the next several months.

Refer to this [Fact Sheet](#) for further information on how the Special Enrollment Confirmation Process will work and what else CMS is doing to improve the SEP process.

Over the next few weeks, CMS will solicit feedback on these new verification requirements. Assisters are encouraged to send their feedback to SEP@cms.hhs.gov.

New Special Enrollment Period Updates to the Marketplace Application

Key Takeaway: On March 4th CMS updated the Marketplace application by adding new attestation language and by clarifying the loss of coverage and permanent move application questions.

New Attestation Language

New language requires consumers to attest that they understand they may be asked to provide additional information, including proof of their eligibility for a Special Enrollment Period, and that, if they do not provide proof of eligibility, they may face penalties including the risk of losing their coverage. This box is on the privacy policy page of the application and must be

checked prior to proceeding through a new or updated application and entering information that may qualify the consumer for a Special Enrollment Period.

Updates to Loss of Minimum Essential Coverage Questions

Both the recent loss of coverage and future loss of coverage questions have been updated to:

- specify that coverage must have been lost within the past 60 days or will be lost within the next 60 days;
- provide examples of coverage that qualifies as Minimum Essential Coverage (MEC); and
- provide a link to a help page that provides a thorough discussion and explanation of MEC.

In addition, new blue boxes have been added to clarify that losing coverage due to nonpayment of premiums does not qualify as loss of MEC for purposes of qualifying for this SEP.

Updates to the Permanent Move Question

The permanent move question has been updated to specify that move must have occurred within the last 60 days and provide examples of which situations do and do not qualify as a permanent move for purposes of qualifying for this SEP.

Additionally, CMS updated text on the [SEP Screener Tool](#) to reflect these application updates. These application updates will be accompanied by other improvements to the SEP application process, which are described [here](#) and are part of the new Special Enrollment Confirmation Process.

###

SUMMARY OF BENEFITS AND COVERAGE (SBC) FAQs (ACA FAQ SET 30)

The Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) are releasing an FAQ clarifying what the intended implementation date for Summary of Benefits and Coverage (SBC) using the new template and associated documents. CMS is also issuing a FAQ which address the timing of the updated SBC template and associated documents and explain that the Departments "intend that health plans and issuers that maintain an annual open enrollment period will be required to use the new SBC template and associated documents beginning on the first day of the first open enrollment period that begins on or after April 1, 2017."

For more information, click here:

Tri-dept FAQ: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQS-30_final-3-11-16.pdf

CMS FAQ: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/SBC-FAQ-Final-3-11-16.pdf>

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TAX SEASON SPOTLIGHT

Key Takeaway: Refer consumers to licensed tax professionals for tax help. Also, don't forget to share information with consumers about health coverage exemptions and the fee.

Health Care Tax Assistance for Consumers

The Marketplace mailed all Form 1095-As to consumers by early February. Insurers, other coverage providers, and some employers have until March 31, 2016 to provide Forms 1095-B and 1095-C to consumers. As consumers receive health care information tax forms and attempt to reconcile Form 8962 to file their federal tax return, they will likely reach out to Assistants for help in understanding the differences between the various forms and how health care affects their taxes. While Assistants are prohibited from helping consumers with filing their taxes (unless you are also a licensed tax professional), being able to refer a consumer to a tax professional is an excellent way to guide a consumer to the help they need.

HHS is collaborating with a wide range of non-profit organizations and some of the nation's largest tax preparers to ensure that the public understands how health care and their taxes intersect. These groups provide resources, advice, and assistance to tax filers across the country. Some are offering on-the-ground, in-person support, while others are providing online tools and software to help guide people through the tax filing process. Consumers can learn more about free tax assistance and filing options – including assistance in their community - by visiting www.IRS.gov/freefile or www.IRS.gov/VITA.

Here are some additional tax related resources that will be helping in your work assisting consumers:

- [Healthcare Tax Tips](#)
- [Answers to Five of Your Questions about the Premium Tax Credit](#)
- [Gathering Your Health Coverage Documentation](#)
- [Affordable Care Act - What to Expect when Filing Your 2015 Tax Return](#)
- [Tips for Choosing a Tax Professional](#)
- [How Health Coverage Affects Your Taxes](#)

IRS Publication 974 on the Premium Tax Credit

[IRS Publication 974](#), Premium Tax Credit, has been revised and is now available on IRS.gov. It provides additional instructions for taxpayers in special situations who purchased 2015 health care coverage from the Health Insurance Marketplace.

Eligible taxpayers will file [Form 8962](#), Premium Tax Credit, using its [instructions](#) and Publication 974. More information about the [premium tax credit](#) is available at IRS.gov/aca.

New Tax Resources:

- [How Health Coverage Affects Your Taxes \(formerly "3 Tips about Marketplace Coverage & Taxes"\)](#)
- No Health Coverage - What that means for your taxes ([Article](#) and [Fact Sheet](#))
- [The Small Business Health Care Tax Credit & Premium Assistance Programs](#)
- [Get Tax Help in Spanish from the IRS](#) (announcement in [Spanish](#))

Help Protect Consumers from Fraud

Key Takeaway: Remind consumers to safeguard their private information when filing their taxes or resolving Marketplace coverage inconsistencies by exercising extreme caution with whom they share their private information.

Tax Preparer Fraud

The Internal Revenue Service (IRS) renewed a consumer alert for e-mail schemes after seeing an approximate 400 percent surge in phishing and malware incidents so far this tax season. The emails are designed to trick taxpayers into thinking these are official communications from the IRS or others in the tax industry, including tax software companies. The phishing schemes can ask taxpayers about a wide range of topics. E-mails can seek information related to refunds, filing status, confirming personal information, ordering transcripts and verifying PIN information. Variations of these scams can be seen via text messages, and the communications are being reported in every section of the country. Read more on this topic [here](#).

As consumers work to file their taxes, share with them the following resources to help protect them from tax fraud:

- ["Dirty Dozen" tax scams for the 2016 filing season](#)
- [IRS Identity Theft Victim Assistance: How It Works](#)
- [How New Identity Security Changes May Affect Taxpayers for 2016](#)
- [Report Phishing and Online Scams](#)
- How to Choose Your Tax Preparer Wisely ([Article](#) and [Video](#))
- [Directory of Federal Tax Return Preparers with Credentials and Select Qualifications](#)
- [Make a Complaint About a Tax Return Preparer](#)

Marketplace Fraud

It's important to help consumers differentiate between legitimate requests for additional information from the Marketplaces and fraudulent phishing attempts from scammers to access consumers' private information. As the Marketplace begins to address application "inconsistencies" or "data matching issues" for consumers' applications for health coverage, some consumers will be asked to provide additional information to verify the data entered on their application. In some cases, the Marketplace may call a consumer directly to request the consumer provide more information that will help resolve application inconsistencies.

Help consumers identify legitimate Marketplace requests by reviewing and sharing the following resources:

- [Protect yourself from Marketplace fraud](#) (Tips, Marketplace outbound phone numbers, when to report suspected fraud)
- [Healthcare and Marketplace Related Scam Indicators](#)
- [Latest Health related Scam Alerts](#)
- [What to do if your information is lost or exposed](#)

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TIPS FOR PROVIDING PROOF OF NO INCOME

Key Takeaway: In providing proof of no income to resolve an income inconsistency, a consumer may provide a written explanation that they have zero income. They may also provide documentation that indicates zero income. They can also submit documentation that showed income from a previous year, along with an explanation why they will not receive income this year.

To resolve “inconsistencies” or “[data matching issues](#)” on Marketplace applications for health coverage, the Marketplace will ask consumers to provide additional information to verify the data entered on their applications, like their income. In cases where a consumer encounters an income related inconsistency and the consumer earned no income within the year, he or she will need to provide the Marketplace proof of no income to resolve the inconsistency.

Consumers who are young adults, students, or lawfully present immigrants with income under 100% FPL and ineligible for Medicaid due to immigration status may encounter this type of inconsistency. In your work with these populations, let these consumers know that any document that does not specifically indicate zero income must be accompanied by a written explanation that the document is being submitted as proof of \$0 income or a loss of income. For example, a school document that shows the consumer is a student is unlikely to indicate the consumer’s income. Therefore, in addition to the proof of student document, the consumer should also submit a brief written explanation that says the student document is being submitted as proof of \$0 income.

Acceptable documents include:

- A written statement, signed by the consumer, that explains that the consumer does not expect to have any income for the year or experienced a change in income. For example, the statement: “I, [insert name], attest that I do not expect to have any income in 2016.” The consumer should also include in the statement why they have no income (for example if they are going back to school and no longer working, or if they switched jobs and have a change in income), and when that change occurred.
- A document showing that the consumer is a student (for example, a transcript from their school, acceptance letter, class schedule), accompanied by a written explanation that the consumer is not receiving income because they are a full-time student.

- Any document showing that the consumer has lost income for the previous year, such as a letter of termination from a job. Please include the date the job ended as well. Consumers that have terminations in the current year, should report their change in income to the Marketplace.
- Any document from a federal or state benefit-granting agency showing that the consumer has \$0 income for the year (for example, a Medicaid eligibility notice or food stamp eligibility notice that shows the consumer's household income as zero).

Remember that supporting documents to resolve their inconsistency can be [uploaded directly to the consumer's Marketplace account](#). Also, don't forget to refer consumers to the [Marketplace's list of acceptable documents](#) to help them resolve other types of application inconsistencies.

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MARKETPLACE NOW USING 2016 FPL'S TO CALCULATE MEDICAID AND CHIP ELIGIBILITY

The Marketplaces uses Federal Poverty Levels (FPL) to determine consumers' eligibility for certain programs and benefits. Beginning March 4th, the Marketplaces will begin to use 2016 FPL numbers to calculate eligibility for Medicaid and the Children's Health Insurance Program (CHIP). 2015 numbers will continue to be used to calculate eligibility for savings on private insurance plans for 2016. Here are some helpful resources regarding Federal Poverty Levels:

- [Updated 2016 Federal Poverty Level Numbers](#)
- [See if you may qualify for savings in your state](#)

###

HELPING CONSUMERS WHO QUALIFY FOR A HEALTH COVERAGE EXEMPTION AND UNDERSTANDING THE FEE

As you assist consumers with understanding their Health Care Information Tax Forms this spring, remember that some consumers may qualify for a health coverage exemption and need help in understanding what an exemption is and how to apply for one. Let consumers know that if they do not have health care coverage for only 1 or 2 months throughout the year, they don't have to pay the [fee](#). Other exemptions from the fee are also available based on other circumstances.

Since not every health coverage exemption can be claimed on the federal tax return, encourage consumers to use "[Find Health Coverage Exemptions That Apply to You](#)" tool on [healthcare.gov](#) in advance of preparing their tax returns. If you encounter consumers who went without Minimum Essential Coverage (MEC) and didn't qualify for a health coverage exemption, share with them this information about the [Individual Shared Responsibility Payment](#) and how much they may be liable to pay on their federal tax return. Here are some Tax and Exemption resources that may be helpful in assisting consumers:

- [Exemptions from the Individual Shared Responsibility Fee](#) (January 29, 2016 Marketplace Webinar Slide Deck)

- [Shared Responsibility Payment & Exemptions Information](#) (Technical Assistance Resources)
- [No Health Coverage? What That Means for Your Taxes](#)

###

REMIND CONSUMERS TO RESOLVE THEIR DATA MATCHING INCONSISTENCIES

Key Takeaway: Encourage consumers to send documents as soon as possible and by the date shown in their notice to avoid problems with the programs and savings they may qualify for.

While applying for Marketplace coverage, a consumer may have received an email saying there were “inconsistencies” or “data matching issues” in their application. Let consumers know that this is because some information provided in their application for Marketplace coverage didn’t match the Marketplace’s data sources.

The Marketplace will ask the consumer for documents to verify the data entered on their application. Let consumers know they can mail in the requested documents or upload them directly to their Marketplace account (with uploading being the preferred method).

Here are some resources to help consumers resolve inconsistency or data matching issues in their application:

- A [list of documents](#) that consumers can submit to resolve different types of inconsistencies.
- How to [submit a document to a Marketplace account](#)
- Tips to [Resolve Outstanding Data Matching Issues](#)

Remind consumers to send documents as soon as possible and by the date shown in their notice to avoid problems with the programs and savings they may qualify for. Data matching issues must be resolved for consumers to stay covered in the Health Insurance Marketplace and/or maintain the same level of **financial assistance**. Consumers have at least 90 days after receiving an initial eligibility notice to resolve a data matching issue before the Marketplace changes their eligibility determination. They’ll get a notice explaining how long they have to resolve the issue (the consumer will have either 90, 60, or 30 days depending on how much time has passed since their initial eligibility notice). Consumers will also receive a reminder phone call 14 days before the deadline (Note: Consumers may also receive a notice from your health insurance company).

###

NEWS FOR FEDERALLY-FACILITATED MARKETPLACE AGENTS AND BROKERS - FEBRUARY 2016 EDITION

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

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- *Did You Know?* Reminding Consumers to Pay Their First Month's Premium for Health Insurance
- Follow Us on Twitter
- Contact Us

New Resources for Agents and Brokers

Upcoming Webinars

CMS will be hosting a number of topic-focused webinars in March on the following dates and times:

- **Tax Season Readiness 101:** March 9 from 12:30 – 2:00 PM ET – This webinar will cover an overview of the forms, tips, and tools agents and brokers should be familiar with as they help consumers prepare for the 2015 tax season.
- **SEPs in the FFMs for Plan Year 2016:** March 23 from 1:00 – 2:30 PM ET – This webinar will serve as a refresher on the availability of and requirements around SEPs and changes in circumstances.
- **Assisting Consumers with Complex Situations:** March 30 from 1:00 – 2:30 PM ET – This webinar will explain how to help consumers with multi-tax households and family members enrolling in different qualified health plans (QHPs).

To register for any of the above webinars, log in to www.REGTAP.info and complete the following steps:

1. Select "Training Events" from "My Dashboard."

2. Select the "View" icon next to event title for the webinar you are interested in attending.
3. Select "Register Me."

If you require assistance with webinar registration, contact the Registrar at 800-257-9520 from 9:00 AM – 5:00 PM ET, Monday through Friday or by email at: registrar@REGTAP.info. Registration closes 24 hours prior to each event.

New “Operational Updates and Announcements for Agents and Brokers Participating in the FFM” Webinar Slides Now Available

CMS has posted slides from weeks 12 and 13 of the “Operational Updates and Announcements for Agents and Brokers Participating in the FFM” webinar series. Information about what each of these webinars covered is available on the [Agents and Brokers Resources webpage](#). You can review the slides by selecting one of the following sessions:

- [Week 12](#): January 19, 2016
- [Week 13](#): January 26, 2016

New “Agent and Broker Roadmap to Resources”

CMS has released the [Agent and Broker Roadmap to Resources](#), which provides important information on:

- The Marketplace and other health coverage topics, and links to helpful resources on those topics
- Information you need to know on how to help consumers apply for and enroll in Marketplace plans and other health coverage
- Coverage options available to consumers
- What you need to know about the Marketplace Eligibility and Enrollment process to help consumers get coverage
- How to access Marketplace information and resources in other languages
- How to get the latest information on Marketplace policies and operations

“Operational Tips for Agents/Brokers for Plan Year 2016 in the FFM”

The updated [Operational Tips](#) provides answers to agent and broker questions about consumer enrollment for plan year 2016, including how agents and brokers can assist with enrollments, the Marketplace 2.0 application, the Direct Enrollment Pathway, reenrollment, capturing NPNs on an application, and registration.

New Consumer Decision Support Tools Available at HealthCare.gov

The new [consumer decision support tools](#) piloted earlier this enrollment season are now fully deployed to all visitors to HealthCare.gov. These tools can help consumers more easily search for the plans that best meet their budgets and health care needs.

- The Out of Pocket Cost calculator helps consumers better estimate the cost of their health insurance based on their own personal situation.

- The Doctor, Facility, and Prescription Drug Look-up tools provide consumers with easily searchable information about a plan's networks of doctors and/or medical facilities and the prescription drugs plans may cover.

Consumers will be asked to opt-in to use the tools to be sure they understand limitations with the data. Agents and brokers can help consumers use these tools when reviewing plans at [2016 Health Insurance Plans & Prices](#).

Plan Year 2016 Agent and Broker FFM Registration Completion List

Check the [Agents and Brokers Resources webpage](#) to view the most recent Agent and Broker FFM Registration Completion List for Plan Year 2016, which includes the National Producer Numbers (NPNs) of agents and brokers who have completed plan year 2016 registration requirements for the FFM as of the date listed in the filename. If you completed registration after the date listed, check back and confirm your NPN has been included when the new list is posted. Issuers can review the Agent and Broker FFM Registration Completion List to confirm that agents and brokers with whom they have agreements are authorized to assist consumers in selecting plans through the FFM.

If you completed all of the plan year 2016 agent and broker registration and training requirements for the FFM, you should review the latest list to confirm your NPN is included. You can search for your NPN by clicking the arrow in cell A1, or by using the "Ctrl + F" (or "Command + F") keystroke.

###

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) CORNER

The SHOP Marketplace is Open All Year!

Open enrollment for individuals and families is over, but small employers can still offer their employees' health and dental insurance through the SHOP Marketplace on a monthly basis throughout all of 2016. SHOP Marketplace applications submitted by the 15th of the month go into effect as soon as the 1st of the following month.

Second Quarter Rates Available on February 16

Plan for your SHOP Marketplace enrollments and renewals for the upcoming year. In the SHOP Marketplace, the cost for health and dental plans available may change on a quarterly basis for new enrollments.

As you get ready for your 2016 enrollments, please keep the following key dates in mind:

- February 16, 2016: SHOP Marketplace rates for the Second Quarter available
- May 6, 2016: SHOP Marketplace rates for the Third Quarter available
- August 16, 2016: SHOP Marketplace rates the Fourth Quarter available

Visit [See 2016 Health Insurance Plans & Prices](#) to view SHOP Marketplace health and dental plans available at [Healthcare.gov](#).

Have SHOP Marketplace Renewals Coming Up?

You can begin assisting your clients with their renewals as soon as the applicable quarterly rates become available, 45-60 days before the renewal date. Your clients will also receive renewal notices from the SHOP Marketplace around this time. For more information, visit HealthCare.gov.

New Research Findings on Small Employers and the SHOP Marketplace

The Robert Wood Johnson Foundation commissioned research to conduct focus groups and a national survey with employers with 50 or fewer employees to understand their perspectives on offering health insurance, as well as their awareness of and interest in the SHOP Marketplace. Notably, a majority of small employers expressed an interest in enrolling in SHOP Marketplace coverage when hearing about the benefits of the SHOP Marketplace.

You can download the study's findings in a report or in a recorded version of the webinar conducted on January 14, and view the presentation slides on the [new research findings on small employers and the SHOP Marketplace](#).

###

SPECIAL POPULATIONS — NEW PARENTS AND THEIR NEW CHILDREN ENROLLING IN THE MARKETPLACE OUTSIDE OF OPEN ENROLLMENT

Parents who recently gave birth to, adopted, or are fostering children are eligible for a SEP that will allow them to enroll in QHPs outside of the Open Enrollment period. New parents may experience a change in coverage options or eligibility for advance payments of the premium tax credit (APTC) and CSRs. Remind consumers they should report such events to the Marketplace to find out what changes the addition of children to their households might cause for their coverage. For more information, check out the [Helping New Parents and Their New Children Enroll in the Marketplace Outside of Open Enrollment](#) fact sheet.

###

SPOTLIGHT ON ELIGIBILITY AND ENROLLMENT

Help Consumers Understand the Application Question on Filing Taxes Jointly with a Spouse

CMS has added new language at HealthCare.gov to help consumers better understand questions on the application related to household size, income, and how they plan to file taxes. Consumers who indicate they are married, but do not plan to file a joint federal income tax return with their spouse for 2015, will see the following text to prompt them to consider whether they will file jointly:

If you and your spouse are on the same tax return, select “GO BACK,” and change your answer to “Yes” when we ask if you plan to file a joint federal income tax return with your spouse.

If you and your spouse aren't on the same tax return, select “CONTINUE MY APPLICATION.” If you file separately, you can't get premium tax credits or other savings, unless you meet certain specific exceptions. [[Learn more about other tax filing circumstances](#)].

Help Consumers Estimate their Expected 2016 Income

When helping consumers fill out a Marketplace application, it is important that you remind them that Marketplace savings are based on their expected household income for 2016, not last year's income. Please take a moment to review the steps in the [“How to Estimate Your Expected 2016 Income”](#) article on Healthcare.gov so you can best assist consumers in estimating their expected 2016 income.

While you may provide information to consumers about the APTC reconciliation process and the forms that they will receive, it is important that you not provide any tax filing advice or answer any tax filing questions. Please refer consumers seeking answers to their questions or advice regarding their personal situations to a tax professional for assistance or to the tax assistance options available at: [IRS.gov/freefile](#) or [IRS.gov/VITA](#).

Did You Know?

After consumers have selected a new plan for 2016, they must complete one very important task to finish enrolling — they must pay their first month's premium to their health insurance company, not to HealthCare.gov. As you continue to assist consumers following Open Enrollment, please remind them to pay their premiums to complete the enrollment process. It is important to note that each issuer has different standards, so consumers need to pay careful attention to their premium due date. For more information on helping consumers navigate the payment process for their first month's premiums, review the Healthcare.gov Blog post, [“Reminder: Don't Forget to Pay Your First Month's Premium for Health Insurance.”](#)

###

AGENTS/BROKERS: ASSISTING CONSUMERS ELIGIBLE FOR A SPECIAL ENROLLMENT PERIOD

Although the annual Open Enrollment period is over, you can still assist consumers with enrollment in a 2016 insurance plan through the Federally-facilitated Marketplace (FFM) if they have a life event that qualifies them for a Special Enrollment Period (SEP).

Visit [HealthCare.gov](#) for information about qualifying life events, how to apply for an SEP, and other answers to questions about 2016 SEPs. CMS has also announced several changes to the 2016 SEP process in recent weeks, including a [new SEP Enrollment Confirmation Process](#) and [guidance clarifying, eliminating, and enforcing SEPs](#).

To learn more about SEPs in the FFM for plan year 2016, check out our upcoming webinar on Wednesday, March 23, from 1:00 PM – 2:30 PM Eastern Time. Webinar registration information and instructions are available on the [Agents and Brokers Resources webpage](#).

###

CMS FINALIZES IMPROVEMENTS FOR THE 2017 HEALTH INSURANCE MARKETPLACE

The Centers for Medicare & Medicaid Services (CMS) issued the final annual Notice of Benefit and Payment Parameters for the 2017 coverage year, along with related guidance documents, as part of our ongoing efforts to promote healthy and stable markets that works for consumers and for insurers.

“As the Health Insurance Marketplace continues to mature, we are able to focus on strategies that help it work even better for consumers and insurers,” said Kevin Counihan, CEO of the Health Insurance Marketplaces. “That means making targeted improvements that keep the Marketplace working smoothly for consumers and keeps the Marketplace an attractive place to do business.”

The rule finalizes provisions to: help consumers with surprise out-of-network costs at in-network facilities, provide consumers with notifications when a provider network changes, give insurance companies the option to offer plans with standardized cost-sharing structures, provide a rating on HealthCare.gov of each QHP's relative network breadth (for example, “basic,” “standard,” and “broad”) to support more informed consumer decision-making, and improve the risk adjustment formula.

To help stakeholders plan ahead, CMS also finalized 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 (for example, November 1, 2018 through December 15, 2018 for 2019 coverage).

The fact sheet with details on these key provisions and others can be found here: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-29.html>

In addition to the final Notice of Benefit and Payment Parameters for 2017, CMS released its final Annual Letter to Issuers. This provides issuers interested in offering coverage in states with a Federally-facilitated Marketplace information on key dates for the Qualified Health Plan (QHP) certification process; standards that will be used to evaluate QHPs for certification; and oversight procedures, consumer support policies and programs. The letter is available here: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>

Additionally, CMS released a bulletin on the Rate Filing Justifications for the 2016 Filing Year for Single Risk Pool Compliant Coverage. This bulletin provides guidance on the timing for state Departments of Insurance and health insurance insurers to submit Rate Filing Justifications for proposed rate increases in the individual and small group markets. The guidance, which offers

states greater flexibility than the proposed bulletin, is available here:

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-rate-filing-justification-bulletin-2-29-16.pdf>

CMS released a set of Frequently Asked Questions (FAQs) related to the Moratorium on the Health Insurance Provider Fee (enacted in the Consolidated Appropriations Act of 2016, P.L. 114-113), which suspends collection of this fee for the 2017 plan year. This guidance urges issuers to lower their administrative costs and premiums appropriately to account for the moratorium. The FAQs are available here: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL_9010_FAQ_2-29-16.pdf

Lastly, CMS released guidance addressing the transitional policy for plans that have been continuously renewed since 2014. To allow for a smooth wind-down of transition relief, States and issuers will have the option to renew non-grandfathered individual and small group health policies, but these policies must end no later than December 31, 2017. This approach offers flexibility to States and issuers to align the end of these policies with open enrollment and the start of the calendar year, facilitating smooth transitions to Affordable Care Act-compliant policies. The guidance is available here: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf>

The final Notice of Benefit and Payment Parameters for 2017 rule was placed on display at the Federal Register today, and can be found at: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-04439.pdf> and on 03/08/2016 and available online at <http://federalregister.gov/a/2016-04439>

###

SPECIAL UPDATE: UNDERSTANDING THE CONNECTION BETWEEN HEALTH INSURANCE AND TAXES

Each year, along with the wonder of spring, comes our annual obligation to file our taxes. So it's a good time to be up to date on the connections between health insurance coverage and taxes and it may be an even better time for your community to partner with a voluntary tax assistance program to help educate consumers and help them address this important new requirement.

When you file your taxes, you'll need to include information about your health coverage. Whether you enrolled in coverage, received financial help, or chose to go without coverage there may be tax implications-- including the possibility of a [penalty payment](#). Below are resources that will help you understand your [2015 health coverage status](#) and what you need to do next!

Fact sheets

- [How Health Coverage Affects Your Taxes](#)
- [No Health Coverage? What That Means for Your Taxes](#)

Drop-in articles

- [No Health Coverage in 2015? What That Means for Your Taxes](#)
- [How Health Coverage Affects Your Taxes](#)

###

FREE TAX RETURN PREPARATION FOR QUALIFYING TAXPAYERS

The [Volunteer Income Tax Assistance \(VITA\) program](#) offers free tax help to people who generally make \$54,000 or less, persons with disabilities and limited English speaking taxpayers who need assistance in preparing their own tax returns. IRS-certified volunteers provide free basic income tax return preparation with electronic filing to qualified individuals. You might also consider training to [become a VITA volunteer](#).

In addition to VITA, the [Tax Counseling for the Elderly \(TCE\)](#) program offers free tax help for all taxpayers, particularly those who are 60 years of age and older, specializing in questions about pensions and retirement-related issues unique to seniors.

Before going to a VITA or TCE site, check out the Services Provided and check out the [What to Bring](#) page to ensure you have all the required documents and information our volunteers will need to help you.

[Find a VITA or TCE Site near You](#) or Contact [United Way's MyFreeTaxes](#)

THE FEE FOR NOT HAVING HEALTH INSURANCE

If you can afford health insurance and have chosen not to buy it, you will pay a fee when you file your federal tax return for the year you chose not to have coverage. Called an [individual shared responsibility payment](#), the fee is sometimes called the "penalty," "fine," or "individual mandate."

You will owe the fee for any month you, your spouse, or your tax dependents don't have health insurance that qualifies as [minimum essential coverage](#)-- unless you qualify for an exemption

[Learn about health coverage exemptions.](#)

The fee for not having coverage in 2015: The fee is calculated 2 different ways – as a percentage of your household income, and per person. **You'll pay whichever is higher.**

2% of household income/ **Maximum:** Total yearly premium for the national average price of a Bronze plan sold through the Marketplace

OR

\$325 per adult, \$162.50 per child under 18/**Maximum:** \$975

The fee for not having coverage in 2016 is the higher of these:

2.5% of household income/**Maximum:** Total yearly premium for the national average price of a Bronze plan sold through the Marketplace

OR

\$695 per adult, \$347.50 per child under 18/**Maximum:** \$2,085

[Learn more](#) about estimating and paying the fee.

###

ASPE FINAL ENROLLMENT REPORT & EFFECTUATED

ASPE released a final enrollment report showing Health Insurance Marketplaces nationwide signed up 4.9 million new customers for 2016 coverage during the third Open Enrollment period. In total, 12.7 million people signed up or automatically renewed their plans for 2016 coverage.

Additionally, CMS released a report showing 8.8 million individuals had paid their premiums and had an active policy, or “effectuated” their coverage at the end 2015, up from 6.3 million individuals in 2014.

To read the **press release** detailing more about both reports, visit:

<http://www.hhs.gov/about/news/2016/03/11/nationwide-health-insurance-marketplaces-signed-49-million-new-people-during-third-open-enrollment.html>

To read the full **ASPE report**, please visit: <https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>

To read the **CMS report**, please visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html>

###

ASPE UNINSURED ISSUE BRIEF

ASPE released a new report that finds the provisions of the Affordable Care Act have resulted in an estimated 20 million people gaining health insurance coverage between the passage of the law in 2010 and early 2016.

“Thanks to the Affordable Care Act, 20 million Americans have gained health care coverage,” said HHS Secretary Sylvia M. Burwell. “We have seen progress in the last six years that the country has sought for generations. Americans with insurance through the Health Insurance

Marketplace or through their employers have benefited from better coverage and a reduction in the growth in health care costs.”

To read the full **press release**, visit: <http://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates>

To read the full **report**, visit: <https://aspe.hhs.gov/pdf-report/health-insurance-coverage-and-affordable-care-act-2010-2016>

###

THE FINAL HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2017 HAS BEEN RELEASED

CMS issued the [final rule](#) for the 2017 coverage year, along with related guidance documents, as part of ongoing efforts to promote healthy and stable markets that works for consumers and for insurers. The final payment rule sets standards for issuers and Health Insurance Marketplaces for plan years beginning on or after 1/1/2017. It establishes new standards to improve consumers' Marketplace experience, promotes continuity and stability in the Marketplaces, and ensures coverage is affordable and accessible.

###

Medicare and Medicaid Updates

MEDICARE ADVANTAGE (MA) QUALITY BONUS PAYMENT DEMONSTRATION FINAL REPORT

The Centers for Medicare & Medicaid Services (CMS) completed the three-year Medicare Advantage (MA) Quality Bonus Payment (QBP) Demonstration (“QBP demonstration”) launched in 2012, which extended quality bonus payments established in the Affordable Care Act of 2010 to additional plans based upon Star Ratings. The primary findings of the final evaluation report include: Across the QBP demonstration period (CY 2012-2014), average Star Ratings improved, more beneficiaries enrolled in higher rated plans, and more beneficiaries had access to higher rated plans. While there is no definitive way to attribute these changes (in whole or in part) to the QBP demonstration itself, evaluation analyses do show that the demonstration did not stall or reverse trends – Star Rating and plan enrollment increases that began prior to the demonstration continued throughout the demonstration period—and, in fact, QBP demonstration payments appear associated with reductions in OOP costs for beneficiaries.

For additional information, click here:

<https://innovation.cms.gov/Files/reports/maqbpdemonstration-finalevalrpt.pdf>

###

SUSPENSION OF POLICY PROVIDING FOR AUTOMATIC REDUCTION OF STAR RATINGS FOR CONTRACTS OPERATING UNDER INTERMEDIATE SANCTION

The Centers for Medicare & Medicaid Services (CMS) is issuing this memorandum to announce a change concerning the effect of intermediate sanctions (e.g., suspension of an organization's marketing and enrollment activities) on the calculation of Star Ratings. In response to the draft CY 2017 Call Letter, we received multiple comments suggesting that CMS revise its policy of automatically reducing the Star Ratings of sanctioned contracts to 2.5 stars, or reducing by one star the ratings of those contracts already rated at 2.5 stars or lower. Commenters raised several concerns, including one noting that high-rated contracts can be subjected to a more severe penalty than low-rated contracts as their rating can be reduced by multiple stars to reach 2.5 stars, while low-rated contracts face a rating reduction of only one star. When CMS announced this policy for the 2012 Star Ratings, relatively few contracts achieved ratings of 4 stars or above and fewer than 30 percent of Medicare Advantage plan enrollees were in plans offered under these highly rated contracts. Today, 49 percent of MA contracts, representing 71 percent of MA plan enrollees, have achieved ratings of 4 stars or above, compared to an estimated 17 percent in 2009. Commenters stated that CMS should reevaluate the current policy given these concerns and the state of the MA Star Rating program today. Having considered these comments and the growth in the number of highly rated contracts, CMS agrees that we should reassess the impact of intermediate sanctions on the calculation of Star Ratings. Consequently, effective immediately and on a prospective basis, CMS is suspending the automatic sanctions-based reduction in Star Ratings. We note that CMS retains the right to impose Civil Money

Penalties as appropriate. CMS will re-examine the appropriate relationship between sanctions and Star Ratings. We will propose a revised approach in the draft CY 2018 Call Letter.

We are announcing this change through a Health Plan Management System (HPMS) memo in advance of the 2017 Final Call Letter so that it can be applied prior to the deadline for making adjustments to a contract's Star Ratings based on its sanction status as of March 31, 2016. This requirement is set forth in the 2016 Star Ratings Technical Notes, which provide that Star Ratings for Quality Bonus Payment (QBP) and Medicare Plan Finder (MPF) purposes are to be updated based on sanction status on March 31, 2016. By making this announcement through an HPMS memo prior to this March 31st deadline, CMS can provide contracting organizations with critical information about Star Ratings adjustments according to our established timelines. This change will also be reiterated in the 2017 Final Call Letter.

###

SOURCES SOUGHT NOTICE -INTEGRATION OF PATIENT SAFETY EFFORTS: PARTNERSHIP FOR PATIENTS (PPF) & QUALITY IMPROVEMENT ORGANIZATIONS (QIOS)

The Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality (CCSQ) is issuing a notice as a means of conducting market research to identify parties having an interest in and the capabilities to support the program entitled "Hospital Improvement Innovation Networks (HIINs)". A Request for Proposal (RFP) is anticipated at a later date.

For additional information, on the Sources Sought Notice posted on FedBizOps click here: https://www.fbo.gov/?s=opportunity&mode=form&id=19085c2b489ce1a47e4c3235dc87d159&ab=core&_cview=0

###

5 WAYS TO BECOME AN INFORMED MEDICARE CONSUMER

Each day, you make important choices about your finances, health, privacy, and more.

During [National Consumer Protection Week](#) (NCPW), March 6–12, 2016, non-profit organizations and government agencies can help you take advantage of your rights and make better-informed choices.

There are 5 things you can do to become an informed Medicare consumer:

1. Know your rights. As a person with Medicare, you have certain [rights and protections](#) designed to help protect you and make sure you get the health care services the law says you can get.
2. Protect your identity. Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Keep this personal information safe:
 - Your name

- Your Social Security Number (SSN)
- Your Medicare number (or your membership card if you're in a Medicare Advantage or other Medicare health plan)
- Your credit card and bank account numbers

Get more information on how to [protect yourself from identity theft](#).

3. Help fight Medicare fraud. Medicare fraud takes money from the Medicare program each year, which means higher health care costs for you. Learn how to [report fraud](#).
4. Get involved with other seniors with the [Senior Medicare Patrol](#) (SMP). The SMP educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse.
5. Make informed Medicare choices. Each year during the fall Open Enrollment Period (October 15–December 7), review your plan to make sure it will meet your needs for the next year. If you're not satisfied with your current plan, you can switch during the Open Enrollment Period.

Visit [NCPW.gov](#) to learn more about the campaign, see which agencies and organizations are able to help you, and to find out if there are any activities happening in your area. Also, check out our videos for tips on [preventing Medicare fraud](#) and see how seniors are learning to [stop, spot, and report fraud](#).

###

CMS PUBLISHES MEDICARE FEE-FOR-SERVICE PROVIDER & SUPPLIER LISTS

Posting of ambulance, home health utilization data follows recent provider and supplier moratoria extension

As part of our efforts to improve care delivery, data sharing, and transparency, the Centers for Medicare & Medicaid Services (CMS) is releasing two public data sets regarding the availability and use of services provided to Medicare beneficiaries by ground ambulance suppliers and home health agencies, as well as a list of Medicare fee-for-service (FFS) providers and suppliers currently approved to bill Medicare. The data sets are accessible at <https://data.cms.gov>.

CMS recently published a Federal Register notice on February 2, 2016 (effective January 29, 2016) extending the temporary enrollment moratoria on new ground ambulance suppliers and home health agencies sub-units, and branch locations in the Medicare, Medicaid, and the Children's Health Insurance Programs (CHIP) for an additional six months in seven geographic areas. Such moratoria provisions were authorized by the Affordable Care Act and serve to reduce fraud, waste, and abuse while ensuring that patient access to care is not interrupted.

The enrollment moratoria extension, coupled with these new provider and supplier data tools, signal that the potential for fraud, waste, and abuse that continues to exist in these areas. "CMS has used this powerful monitoring tool several times before to fight fraud, safeguard taxpayer dollars, and protect beneficiaries. By introducing data mapping for these specific, high-risk providers and suppliers in the moratoria areas and, for the first time, making service area data on all other FFS providers and suppliers publicly available, analyses of the data offers additional insight for CMS and its stakeholders," said CMS Deputy Administrator and Center for Program

Integrity Director Shantanu Agrawal, M.D. “Use of these tools gives us evidence of the use, disproportion, and saturation of certain services within Medicare, Medicaid, and CHIP coverage and provides insight beneficial to reducing program threats, assisting law enforcement, and averting harm to patients and the public.”

Future data releases may include comparable information on additional health services outside the seven moratoria areas.

The Moratoria Provider Services and Utilization Data Tool includes interactive maps and a dataset that shows national-, state-, and county-level provider and supplier services and utilization data that can be used by CMS to determine which geographic and health service areas might be considered for a moratorium on new provider and supplier enrollments. The data provides the number of Medicare providers and suppliers servicing a geographic region, identifies moratoria regions at the state and county levels, and identifies the number of people with Medicare benefits who use a specific health service in that region. The data can also be used to reveal service levels related to the number of providers and suppliers in a geographic region. Utilization data and geographic regions for these services can be easily compared using interactive maps.

CMS' ongoing program integrity work has inspired growing stakeholder interest in Medicare provider and supplier enrollment information, Agrawal said. The Public Provider data allow users, including other health plans, to easily access and validate provider and supplier information against Medicare data. Public Provider Enrollment file sets include information on providers and suppliers, nationwide, who are approved to bill Medicare. The data is extracted directly from the Provider Enrollment, Chain and Ownership System (PECOS) and is updated quarterly.

The Moratoria Provider Services and Utilization Data Tool was created using ground ambulance and home health agency paid claims data that reside in CMS systems for Medicare FFS beneficiaries. The data in this release cover the period from October 1, 2014 to September 30, 2015 and will continue to be updated quarterly. Data are available for each of the 50 states, their counties, and the District of Columbia. The data set does not contain any individually identifiable information about Medicare beneficiaries.

The public provider data consist of individual and organizational provider and supplier enrollment information and includes names, National Provider Identifier and other unique identifiers, enrollment type, specialty, and limited address information (City, State, ZIP Code).

For more information on the recent temporary enrollment moratoria extension please see the Federal Register posting at: <http://federalregister.gov/a/2016-01835>.

To view the Ambulance and Home Health Agency data set and a related fact sheet, visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-22.html>.

To view the Public Provider Enrollment data set and a related fact sheet, visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-22-2.html>.

###

CMS BLOG - LESSONS LEARNED: REFLECTIONS ON CMS AND THE SUCCESSFUL IMPLEMENTATION OF ICD-10

<https://blog.cms.gov/2016/02/24/lessons-learned-reflections-on-cms-and-the-successful-implementation-of-icd-10/>

It was early 2015 and we had just gotten through a second successful season with HealthCare.gov, the turnaround that originally brought me into government, when the articles and letters started flying on our next big implementation – one that would affect nearly every physician and hospital in the country. And, anxiety levels were high.

On October 1, 2015, the U.S. health care system transitioned the way patient visits are coded from ICD-9 to the next version ICD-10, a system which sets the stage for meaningful improvements in public health. If people know about ICD-10 at all – and chances are they don't – it's probably from press reports about the more colorful diagnostic codes like "other contact with shark" or "burn due to water-skis on fire, subsequent encounter." More seriously, for people in the health care industry, it was being compared to Y2K, a transition with the potential to create chaos in the health care system.

One representative from the physician community told me that he was concerned that half of physicians in the country wouldn't be ready by the October 1 date. The thought of physicians in small, rural practices unable to run their practices had my complete attention. It also brought home that we are responsible for more and increasingly complex implementations – from HealthCare.gov to ICD-10 to new physician payment systems.

As I look to the future, great implementation is even more central to life at CMS.

In my time in D.C., I've come to see our role as implementing policies in a way that bring them to the kitchen table of the American family and to the clinics and facilities where they receive care. Implementation in this context is a vital responsibility. And there are millions of Americans that count on us to do it well: the senior filling his prescription; the trustee of the community hospital; the parents of a child with disabilities in need of home resources; the doctor who drives for miles to take care of her patients in several rural communities.

Implementation Success: 4 Lessons

It was clear that CMS had an enormous opportunity - after everything we learned from HealthCare.gov – to take the lead in smoothly implementing this new policy. The ICD-10 implementation had all the hallmarks of how CMS could drive a successful implementation and aim for excellence. The approach we took, which has become our doctrine for getting things done, had four major elements:

Lesson 1: Be Customer Focused

We believe we must always start from the perspective of the real-world needs of the people who live with the results of our implementation at the center of our work. And in the case of ICD-

10, listening and learning about the issues small physician practices were facing helped us understand their resource and technical assistance needs, as well as their concerns over claims payment and cash flow.

In response, we launched "The Road to 10" aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation. CMS also released provider training videos that offered helpful ICD-10 implementation tips and a wealth of other material on [CMS.gov/icd10](https://www.cms.gov/icd10). Finally, Medicare offered an unprecedented level of external testing with its three periods of voluntary end-to-end testing for physicians and other clinicians.

Lesson 2: Be Highly Collaborative

Because health care is still fragmented, CMS can't work alone in implementing major changes. If it wasn't for our close partnerships with the American Medical Association (AMA), the American Hospital Association, the American Health Information Management Association, state medical societies, physicians and other clinicians, billing agencies, equipment suppliers, and a variety of stakeholders, the ICD-10 implementation would not have gone as smoothly as it did. Because we listened to and collaborated with our partners, we were able to address concerns and multiply our ability to get resources to physicians. Several physician groups went from being very concerned about our approach to leading the charge on implementation. As AMA said, "We appreciate that CMS is adopting policies to ease the transition to ICD-10 in response to physicians' concerns that inadvertent coding errors or system glitches during the transition to ICD-10 may result in audits, claims denials, and penalties under various Medicare reporting programs."

Lesson 3: Be Responsive and Accountable

At CMS, we recognize that challenges happen and our efforts must be to anticipate them, make them visible, and be accountable for solving them. In the case of ICD-10, the potential for challenges weren't only in our own systems, but in the systems of any physician office, hospital, or state Medicaid plan. At the suggestion of physician groups, we named an ICD-10 Ombudsman. Just as importantly, we committed to a three-business-day turnaround for every question or concern that came in from a provider. **In the first month of implementation, we received approximately 1,000 inquiries and responded to 100 percent of them within three business days.** We will never achieve perfection, but we will be visible and hold ourselves accountable for solving problems.

Lesson 4: Be Driven by Metrics

It's not glamorous, but daily spreadsheets and scorecards keep complex implementations on track. Once we hit October 1, there were critical metrics to track. If doctors were sending us fewer claims, more claims than usual were denied, or a particular state was having trouble processing Medicaid claims, we needed to know as soon as possible.

Rather than waiting for the phone to ring, the CMS team created a scorecard and heat map to locate and track issues as they occurred. We launched an ICD-10 Coordination Center to handle any issues as they arose. A few days after ICD-10 launched, I received a call from a

large physician organization representative asking me how things were going. I pulled out a version of the table below and read him the data. "This really is a new CMS," he told me.

Final 2015 ICD-10 Claims Dashboard Medicare Fee-for-Service Metrics

Metrics	Historical Baseline	Q4 CY 2015
Total Claims Submitted	4.6 Million per day	4.6 Million per day
Total Claims Rejected	2% of total claims submitted	1.9%
Total ICD-10 Claims Rejected	0.17% of total claims submitted	0.07%
Total ICD-9 Claims Rejected	0.17% of total claims submitted	0.07%
Total Claims Denied	10% of total claims processed	9.9%

*NOTE: Metrics for total ICD-9 and ICD-10 claims rejections were estimated based on end-to-end testing conducted in 2015 since CMS has not historically collected this data. Other metrics are based on historical claims submissions.

Moving Forward

For thousands of physicians and other clinicians around the country, the change to ICD-10 was a big undertaking, requiring time, planning, and a period of adjustment. But on October 1, proper execution and good implementation made all the difference. On the big day, the ICD-10 Coordination Center was packed, and the CMS teams and our partners were geared up and ready to make sure that any burden on physicians could be minimized and concerns quickly addressed.

With preparation, planning, a focus on the customer, collaboration, clear accountability, and metrics, the dire Y2K fears didn't come to pass. Instead, ICD-10 became like what actually occurred on Y2K, an implementation and transition most people never heard about.

With good implementations, we never declare victory and are still at the ready to continually improve. For those who still need help, CMS continues to provide technical support and respond to inquiries. For more information, visit www.cms.gov/ICD10.

The magnitude of CMS's big, complex implementations have accelerated in recent years. And over the next several years, we will be a part of implementing big and important changes that spend our health care dollars more wisely and keep people healthier – from how we pay for care to collecting and publishing data on how care is paid for to building consumer websites evaluating nursing homes to protecting beneficiary privacy and security. Because these changes impact consumers and physicians and other clinicians' daily lives, CMS is responsible to the American people to make health care work better for the consumer and better on the front lines of health care.

###

PROGRAM INTEGRITY ENHANCEMENTS TO THE PROVIDER ENROLLMENT PROCESS (CMS-6058-P)

This proposed rule is part of CMS's ongoing and continuous effort to prevent questionable providers and suppliers from entering the Medicare program and enhance our ability to promptly identify and act on instances of improper behavior.

Summary

CMS is proposing new regulations that implement additional provider enrollment provisions of the Affordable Care Act to help make certain that entities and individuals who pose risks to the Medicare program and beneficiaries are kept out of or removed from Medicare for extended periods.

Background

These enhancements, if finalized, would allow CMS to take action to remove or prevent the enrollment of health care providers and suppliers that attempt to circumvent Medicare's enrollment requirements through name and identity changes as well as through elaborate, inter-provider relationships. The proposed provisions will also address other program integrity issues and vulnerabilities--such as cases where providers and suppliers avoid paying their Medicare debts by reenrolling as a different entity.

CMS now utilizes over 300 different state and federal databases to perform continuous license and background monitoring. We've conducted nearly 230,000 clinical location site visits and over 2,000 fingerprint checks since 2011. We also collaborate and communicate with states to ensure they have access to this important information and are making the same changes in their Medicaid systems. This helpful infographic details CMS' gains in removing bad actors and other program integrity successes:

HEALTH CARE PROVIDER ENROLLMENT

THE GATEWAY TO THE MEDICARE PROGRAM

AFFORDABLE CARE ACT PROVISIONS (2011 – 2015)
as of May 2015



\$1.4 BILLION¹

Of the \$2.4 Billion, this is the total estimated cost savings for Medicare revoked providers from Affordable Care Act provisions.

\$1 BILLION

Of the \$2.4 Billion, this is the total estimated cost savings for Medicare revoked providers from existing CMS authorities.



¹ The savings associated with each Affordable Care Act provision subcategory on the right will not sum to the total estimated cost savings for all Affordable Care Act provisions. This is because some provider encounters may fall into more than one subcategory (e.g., a provider may have multiple enrollments, one revoked due to Advanced Provider Screening and the other because of revalidation), and the reported dollars remove any double counting of savings.

Major Provisions

- Disclosure of Affiliations:** Would require health care providers and suppliers to report affiliations with entities and individuals that: (1) currently have uncollected debt to Medicare, Medicaid, or CHIP; (2) have been or are subject to a payment suspension under a federal health care program or subject to an Office of Inspector General (OIG) exclusion; or (3) have had their Medicare, Medicaid, or CHIP enrollment denied or revoked. CMS could deny or revoke the provider's or supplier's Medicare, Medicaid, or CHIP enrollment if CMS determines that the affiliation poses an undue risk of fraud, waste, or abuse.
- Different Name, Numerical Identifier, or Business Identity:** CMS could deny or revoke a provider's or supplier's Medicare enrollment if CMS determines that the provider or supplier is currently revoked under a different name, numerical identifier, or business identity.

- **Abusive Ordering/Certifying:** Would allow CMS to revoke a physician's or eligible professional's Medicare enrollment if he or she has a pattern or practice of ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements.

- **Increasing Medicare Program Re-enrollment Bars:** Would improve protection of the Medicare Trust Funds and program beneficiaries by:
 - Raising the existing maximum re-enrollment bar from three years to 10 years
 - Allowing CMS to add three more years to the provider's or supplier's re-enrollment bar if the provider attempts to re-enroll in Medicare under a different name, numerical identifier, or business identity
 - Imposing a maximum 20-year reenrollment bar if the provider or supplier is being revoked from Medicare for the second time

- **Other Public Program Termination:** Would permit CMS to deny or revoke a provider's or supplier's Medicare enrollment if: (1) the provider or supplier is currently terminated from participation in a particular Medicaid program or any other federal health care program under any of its current or former names, numerical identifiers, or business identities; or (2) the provider's or supplier's license is revoked in a state other than that in which the provider or supplier is enrolled or enrolling.

- **Expansion of Ordering/Certifying Requirements:** Would permit CMS to require that physicians and eligible professionals who order, certify, refer, or prescribe any Part A or B service, item, or drug must be enrolled in or validly opted-out of Medicare.

###

2016 NEW HARDSHIP EXEMPTIONS DEADLINE

CMS is extending the application deadline for the Medicare EHR Incentive Program hardship exception process that reduces burden on clinicians, hospitals, and critical access hospitals (CAHs). The new deadline for Eligible Professionals, Eligible Hospitals and Critical Access Hospitals is July 1, 2016. CMS is extending the deadline so providers have sufficient time to submit their applications to avoid adjustments to their Medicare payments in 2017.

In January, CMS posted new, streamlined hardship exception application forms that reduce the amount of information that eligible professionals (EPs), eligible hospitals, and CAHs must

submit to apply for an exception. The new applications and instructions for providers seeking a hardship exception are [available here](#).

###

ACCOUNTABLE HEALTH COMMUNITIES UPDATE: APPLICATION DEADLINE EXTENSION

Thanks again for your interest in the Accountable Health Communities (AHC) model. We have received feedback from applicants requesting that we provide more time for the preparation of their application. Based on those requests, **we are extending the Accountable Health Communities Model application deadline to Wednesday, May 18, 2016, at 1:00 PM EST.**

As always, feel free to reach out if you have any questions, but please also see if we've previously answered your question by checking our FAQ page (<https://innovation.cms.gov/initiatives/ahcm/faq.html>).

Sincerely, The AHC Team

###

SWING BED SERVICES FACT SHEET — REVISED

A revised [Swing Bed Services](#) Fact Sheet is available. Learn about:

- Swing bed services background
- Requirements that apply to hospitals and Critical Access Hospitals
- Payments

###

CMS PROPOSES TO TEST NEW MEDICARE PART B PRESCRIPTION DRUG MODELS TO IMPROVE QUALITY OF CARE AND DELIVER BETTER VALUE FOR MEDICARE BENEFICIARIES

Next step to address access, affordability, and innovation in prescription drugs

The Centers for Medicare & Medicaid Services (CMS) announced a proposed rule to test new models to improve how Medicare Part B pays for prescription drugs and supports physicians and other clinicians in delivering higher quality care. CMS values public input and comments as part of the rulemaking process, and looks forward to continuing to work with stakeholders through the rulemaking process to maximize the value and learning from the proposed tests.

Medicare Part B covers prescription drugs that are administered in a physician's office or hospital outpatient department, such as cancer medications, injectables like antibiotics, or eye care treatments. The proposed Medicare Part B Model would test new ways to support physicians and other clinicians as they choose the drug that is right for their patients.

The proposed rule is designed to test different physician and patient incentives to do two things: drive the prescribing of the most effective drugs, and test new payment approaches to reward positive patient outcomes. Among the approaches to be tested are the elimination of certain incentives that work against the selection of high performing drugs, as well as the creation of positive incentives for the selection high performing drugs, including reducing or eliminating patient cost sharing to improve patients' access and appropriate use of effective drugs.

"First and foremost, our job is to get beneficiaries the medications they need. These proposals would allow us to test different ways to help Medicare beneficiaries get the right medications and right care while supporting physicians in the process," said Andy Slavitt, Acting Administrator for CMS. "This is consistent with our focus on testing value-based care models like we have been doing with physicians and hospitals in ACOs. Models like this one can help doctors and other clinicians do what they do best: choose the medicine and treatment that keeps their patients healthy."

Today's proposal is part of the Administration's broader strategy to encourage better care, smarter spending, and healthier people by paying for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality.

"These models would test how to improve Medicare beneficiaries' care by aligning incentives to reward value and the most successful patient outcomes," said Dr. Patrick Conway, CMS Deputy Administrator for Innovation and Quality & CMS Chief Medical Officer. "The choice of medications for beneficiaries should be driven by the best available evidence, the unique needs of the patient, and what best promotes high quality care."

Prescription drug spending in the U.S. was about \$457 billion in 2015, or 16.7 percent of overall health spending, according to a report also released today. In 2015, Medicare Part B spent \$20 billion on outpatient drugs administered by physicians and hospital outpatient departments.

The proposed rule seeks comments on testing six different alternative approaches for Part B drugs to improve outcomes and align incentives to improve quality of care and spend dollars wisely; these include:

- **Improving incentives for best clinical care.** Physicians often can choose among several drugs to treat a patient, and the current Medicare Part B drug payment methodology can penalize doctors for selecting lower-cost drugs, even when these drugs are as good or better for patients based on the evidence. Today, Medicare Part B generally pays physicians and hospital outpatient departments the average sales price of a drug, plus a 6 percent add-on. The proposed model would test whether changing the add-on payment to 2.5 percent plus a flat fee payment of \$16.80 per drug per day changes prescribing incentives and leads to improved quality and value. The proposed change to the add-on payment is budget neutral.
- **Discounting or eliminating patient cost-sharing.** Patients are often required to pay for a portion of their care through cost-sharing. This proposed test would decrease or eliminate cost sharing to improve beneficiaries' access and appropriate use of effective drugs.

- **Feedback on prescribing patterns and online decision support tools.** This proposed test would create evidence-based clinical decision support tools as a resource for providers and suppliers focused on safe and appropriate use for selected drugs and indications. Examples could include best practices in prescribing or information on a clinician's prescribing patterns relative to geographic and national trends.
- **Indications-based pricing.** This proposed test would vary the payment for a drug based on its clinical effectiveness for different indications. For example, a medication might be used to treat one condition with high levels of success but an unrelated condition with less effectiveness, or for a longer duration of time. The goal is to pay for what works for patients.
- **Reference pricing.** This proposed model would test the practice of setting a standard payment rate—a benchmark—for a group of therapeutically similar drug products.
- **Risk-sharing agreements based on outcomes.** This proposed test would allow CMS to enter into voluntary agreements with drug manufacturers to link patient outcomes with price adjustments.

Today's announcement is a continuation of the Department of Health and Human Services' (HHS) work from last fall when HHS convened a forum that brought together consumers, physicians, clinicians, employers, manufacturers, health insurance companies, representatives from state and federal government, and other stakeholders to discuss ideas on how the health care system can meet the dual imperatives of encouraging drug development and innovation, while ensuring access and affordability for patients.

A fact sheet with more information about the proposed rule is available at:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-08.html>.

A fact sheet with more information about what Medicare beneficiaries need to know about the proposed model is available at:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-08-2.html>.

The proposed rule will be open to a 60-day comment period. CMS is accepting comment on the proposed rule through May 9, 2016. The proposed rule is available for viewing at:

<https://www.federalregister.gov/public-inspection>.

Additional information on the proposed rule is available at:

<https://innovation.cms.gov/initiatives/part-b-drugs>.

To learn more about Medicare Part B Drugs: Pricing and Incentives visit:

<https://aspe.hhs.gov/pdf-report/medicare-part-b-drugs-pricing-and-incentives>.

To read an issue brief on Observation Trends in Prescription Drug Spending visit:

<https://aspe.hhs.gov/pdf-report/observations-trends-prescription-drug-spending>.

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2015 HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC) PROGRAM REPORT

HHS OIG, CMS and the US Department of Justice released their FY 2015 report on fraud recovery efforts through the Health Care Fraud and Abuse Control (HCFAC) Program. The activities of the HCFAC program are critically important to protecting the Medicare and Medicaid programs from fraud. In FY 2015, the government recovered \$2.4 billion and saw a \$6.10 ROI for every \$1 invested into the program.

To read the complete report, visit: <http://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf>

To read a quick fact sheet, visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-26.html>

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NEW AND UPDATED FAQs PROVIDE GUIDANCE ON PUBLIC HEALTH REPORTING REQUIREMENTS FOR THE EHR INCENTIVE PROGRAMS

The Centers for Medicare & Medicaid Services (CMS) has published frequently asked questions (FAQs) about the public health reporting objective for the [Medicare and Medicaid Electronic Health Record \(EHR\) Incentive Programs](#). These include three new FAQs about when providers can register their intent to report to a registry, what a provider should do in 2016 if they did not previously intend to report to a public health reporting measure, and the alternate exclusions available for public health reporting in 2016.

For More Information

- [CMS EHR Incentive Program Website](#)
- [Eligible Professionals: Public Health Reporting in 2015](#)
- [Eligible Hospitals /CAHs: Public Health Reporting in 2015](#)
- [CMS EHR Incentive Program FAQs](#)

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MEDICAID & CHIP: DECEMBER 2015 MONTHLY APPLICATIONS, ELIGIBILITY DETERMINATIONS AND ENROLLMENT REPORT

The Centers for Medicare & Medicaid Services (CMS) released a monthly report on state Medicaid and Children's Health Insurance Program (CHIP) data represents state Medicaid and CHIP agencies' eligibility activity for the calendar month of December 2015. This report measures eligibility and enrollment activity for the entire Medicaid and CHIP programs in all

states , reflecting activity for all populations receiving comprehensive Medicaid and CHIP benefits in all states, including states that have not yet chosen to adopt the new low-income adult group established by the Affordable Care Act.

This data is submitted to CMS by states using a common set of indicators designed to provide information to support program management and policy-making related to application, eligibility, and enrollment processes. As with previous reports, this month's report focuses on those indicators that relate to the Medicaid and CHIP application and enrollment process.

Click here to view the report (PDF): <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf>

For additional information and Excel Sheet click here (Dec. 2015):

<https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html>

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AVAILABILITY OF HITECH ADMINISTRATIVE MATCHING FUNDS TO HELP PROFESSIONALS AND HOSPITALS ELIGIBLE FOR MEDICAID EHR INCENTIVE PAYMENTS CONNECT TO OTHER MEDICAID PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) issue a letter that updates guidance about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers. CMS previously issued guidance on this topic in State Medicaid Director (SMD) Letter #10-016

Click here to view the SMD letter: <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf>

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EDUCATIONAL TOOL FOR RURAL HEALTH PROVIDERS

A revised [MLN Suite of Products & Resources for Rural Health Providers](#) Educational Tool is available.

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CMS RELEASES SKILLED NURSING FACILITY UTILIZATION AND PAYMENT DATA

Data serve as comprehensive resource for information on skilled nursing facility costs and services

As part of our efforts to increase the transparency of federal health programs, the Centers for Medicare & Medicaid Services (CMS) today released a public data set that provides information on services provided to Medicare beneficiaries by skilled nursing facilities (SNFs). The Skilled Nursing Facility Utilization and Payment Public Use File (SNF PUF) contains information on utilization, payments, and submitted charges organized by provider, state, and resource utilization group (RUG). The data include information on 15,055 skilled nursing facilities, over 2.5 million stays, and almost \$27 billion in Medicare payments for 2013. The data set does not contain any individually identifiable information about Medicare beneficiaries.

“The Skilled Nursing Facility data released today is yet another example of our commitment to greater data transparency,” said CMS Chief Data Officer Niall Brennan. “CMS believes that when information flows more freely, the health care system functions more efficiently. This leads to better care, smarter spending, and healthier people.”

In addition to information on payments and charges, the SNF PUF contains information on two categories of RUGs for patients who receive a significant amount of therapy: Ultra-High (RU) and Very High (RV) Rehabilitation RUGs. Consistent with prior CMS findings, the SNF PUF shows that for these two RUGs, the amount of therapy provided is often very close to the minimum amount of minutes needed to qualify a patient for these categories. Medicare SNF per diem payment amounts for rehabilitation RUGs are primarily based on therapy minutes and payment amounts for these two RUGs can exceed payments for comparable RUGs with fewer therapy minutes by more than 25 percent.

“CMS strives to ensure that patient need, rather than payment system incentives, are driving the provision of therapy services,” says Dr. Shantanu Agrawal, Deputy Administrator for Program Integrity and Director of the Center for Program Integrity. “These concerns have prompted us to refer this issue to the Recovery Auditor Contractors (RAC) for further investigation, and our hope is that data transparency will facilitate real changes.”

The SNF PUF was created from CMS administrative claims data for Medicare beneficiaries enrolled in the fee-for-service program available from the CMS Chronic Condition Data Warehouse (www.ccwdata.org). The data cover calendar year 2013 and is based on SNF Part A institutional claims.

To view a fact sheet on the Skilled Nursing Facility data set, visit:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-09.html>

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Upcoming Webinars and Events

MEDICARE FOR DUALY ELIGIBLE AND LOW-INCOME PEOPLE UNDER AGE 65

March 17, 2016, 1:00 PM - 2:00 PM Central

Register now at: <https://attendee.gotowebinar.com/register/7598332706003075585>

This free webinar is the second in a [series](#) hosted by the Center for Medicare Advocacy pursuant to a grant from the Administration on Community Living.

Join [Justice in Aging](#)'s Directing Attorneys Georgia Burke and Jennifer Goldberg to explore issues relating to those under age 65 who are eligible for both Medicare and Medicaid, as well as other services for low-income beneficiaries.

This presentation will include an overview of:

- Programs that help with Medicare premiums and co-insurance
- Billing protections for people with low incomes
- Tips for navigating the intersections of Medicare and Medicaid.

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REAL-TIME CLINICIAN CONSULTATION SERVICES FOR SUBSTANCE USE MANAGEMENT

March 18, 2016, 11:00 am

FREE REGISTRATION IN ADVANCE IS REQUIRED. TO REGISTER, PLEASE GO TO:

<https://hrsa.connectsolutions.com/real-time-clinical-consultation-services/event/registration.html>

Managing substance use within the context of providing care is always challenging. Because most patients in busy clinical settings have a wide range of complex medical and social needs, providers often require timely support in addressing the difficult issues of addiction, chronic pain, and behavioral health. The array of medication options, issues of safety, and the rapidly evolving regulatory environment add complexity to the care of a patient with a substance use disorder. Consultation with experts can provide practical help in choosing among specific care and intervention options.

This webinar aims to raise awareness about the Substance Use Warmline, a free and confidential consultation telephone service for primary care and other clinicians which is based at the HRSA-funded Clinician Consultation Center (CCC) at San Francisco General Hospital.

This service provides real-time access to expert clinical consultation when the opportunities for intervention and patient education are greatest. Participants will learn about the Warmline and how real cases have been resolved by the CCC's multi-disciplinary team of expert physicians, clinical pharmacists, and nurses.

Presenters:

HRSA

CAPT Nidhi Jain, MD, MPH
Regional Medical Consultant
Region IX/San Francisco, CA

The Clinician Consultation Center

Joanna Eveland, MS, MD
Clinical Lead
Scott Steiger, MD
Substance Use Specialist

Brenda Goldhammer, MPH
Program Manager

For more information, please contact CAPT Nidhi Jain at 415-437-8611 or njain@hrsa.gov

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MARKETPLACE APPEALS PROCESS

March 24, 2016, 1:00 pm – 2:30 pm Central

[Register now](#)

The webinar, presented in partnership with the National Health Law Program, will provide information on marketplace appeals. It will detail what decisions can be appealed, how to file an appeal, and ways to expedite the appeal process.

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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 with the word "Unsubscribe" in the subject line.