CMS Region 7 Updates

03/10/2017

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HHS OIG Hotline Scam

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently confirmed that the HHS OIG Hotline telephone number is being used as part of a telephone spoofing scam targeting individuals throughout the country. These scammers represent themselves as HHS OIG Hotline employees and can alter the appearance of the caller ID to make it seem as if the call is coming from the HHS OIG Hotline 1-800-HHS-TIPS (1-800-447-8477). The perpetrator may use various tactics to obtain or verify the victim's personal information, which can then be used to steal money from an individual's bank account or for other fraudulent activity. HHS OIG takes this matter seriously. We are actively investigating this matter and intend to have the perpetrators prosecuted.

It is important to know that HHS OIG will not use the HHS OIG Hotline telephone number to make outgoing calls and individuals should not answer calls from 1-800-HHS-TIPS (1-800-447-8477). We encourage the public to remain vigilant, protect their personal information, and guard against providing personal information during calls that purport to be from the HHS OIG Hotline telephone number. We also remind the public that it is still safe to call into the HHS OIG Hotline to report fraud. We particularly encourage those who believe they may have been a victim of the telephone spoofing scam to report that information to us through the HHS OIG Hotline 1-800-HHS-TIPS (1-800-447-8477) or spoof@oig.hhs.gov. Individuals may also file a complaint with the Federal Trade Commission 1-877-FTC-HELP (1-877-382-4357).

Consumer Alerts: https://oig.hhs.gov/fraud/consumer-alerts/alerts/phone-scam.asp

###

ACA/Marketplace Updates

NEW CMS Issues Proposed Rule to Increase Patients' Health Insurance Choices for 2018

On February 15, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for 2018, which puts forward new reforms to stabilize the individual and small group health insurance markets. This proposed rule would make changes to special enrollment periods, the annual open enrollment period, guaranteed availability, network adequacy rules, essential community providers, and actuarial value requirements; and announces upcoming changes to the qualified health plan certification timeline.

"Americans participating in the individual health insurance markets deserve as many health insurance options as possible," said Dr. Patrick Conway, Acting Administrator of the Centers for Medicare & Medicaid Services. "This proposal will take steps to stabilize the Marketplace, provide

more flexibility to states and insurers, and give patients access to more coverage options. They will help protect Americans enrolled in the individual and small group health insurance markets while future reforms are being debated."

The rule proposes a variety of policy and operational changes to stabilize the Marketplace, including:

- **Special Enrollment Period Pre-Enrollment Verification:** The rule proposes to expand pre-enrollment verification of eligibility to individuals who newly enroll through special enrollment periods in Marketplaces using the HealthCare.gov platform. This proposed change would help make sure that special enrollment periods are available to all who are eligible for them, but will require individuals to submit supporting documentation, a common practice in the employer health insurance market. This will help place downward pressure on premiums, curb abuses, and encourage year-round enrollment.
- **Guaranteed Availability:** The rule proposes to address potential abuses by allowing an issuer to collect premiums for prior unpaid coverage, before enrolling a patient in the next year's plan with the same issuer. This will incentivize patients to avoid coverage lapses.
- **Determining the Level of Coverage:** The rule proposes to make adjustments to the de minimis range used for determining the level of coverage by providing greater flexibility to issuers to provide patients with more coverage options.
- **Network Adequacy:** The proposed rule takes an important step in reaffirming the traditional role of states to serve their populations. In the review of qualified health plans, CMS proposes to defer to the states' reviews in states with the authority and means to assess issuer network adequacy. States are best positioned to ensure their residents have access to high quality care networks.
- **Qualified Health Plan (QHP) Certification Calendar:** In the rule, CMS announces its intention to release a revised timeline for the QHP certification and rate review process for plan year 2018. The revised timeline would provide issuers with additional time to implement proposed changes that are finalized prior to the 2018 coverage year. These changes will give issuers flexibility to incorporate benefit changes and maximize the number of coverage options available to patients.
- **Open Enrollment Period:** The rule also proposes to shorten the upcoming annual open enrollment period for the individual market. For the 2018 coverage year, we propose an open enrollment period of November 1, 2017, to December 15, 2017. This proposed change will align the Marketplaces with the Employer-Sponsored Insurance Market and Medicare, and help lower prices for Americans by reducing adverse selection.

The proposed rule can be found here: https://www.federalregister.gov/public-inspection/

###

Equitable Relief for Beneficiaries Dually Enrolled in Medicare and Marketplace

CMS is offering assistance to Medicare beneficiaries currently enrolled in Medicare Part A and the Marketplace for individuals or families. This assistance provides eligible individuals with an opportunity to enroll in Medicare Part B without penalty. Further, CMS is offering assistance to eligible individuals who were dually enrolled in Medicare Part A and the Marketplace for individuals and families and subsequently enrolled in Medicare Part B with a penalty. This

assistance provides these individuals an opportunity to request a reduction in their Medicare Part B late enrollment penalty.

For more information, click here: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html

###

Assistance for Individuals with Medicare Part A and Marketplace Coverage Information for SHIPs and Marketplace Assisters

CMS is offering equitable relief to certain Medicare beneficiaries currently enrolled in Medicare Part A and coverage through the individual Marketplace (i.e., a Marketplace plan for individuals or families and not for employers (also referred to as SHOP)). This equitable relief provides eligible individuals with an opportunity to enroll in Medicare Part B without penalty. Further, CMS is offering equitable relief to eligible individuals who were dually enrolled in Medicare Part A and coverage through the Marketplace and subsequently enrolled in Medicare Part B with a late enrollment penalty. This equitable relief provides these individuals an opportunity to request a reduction in their Medicare Part B late enrollment penalty. This tip sheet explains the equitable relief, eligibility criteria and steps for Medicare beneficiaries if they want to enroll in Medicare Part B or request a Medicare Part B late enrollment penalty reduction.

Q1. Why is CMS offering this equitable relief?

Coverage under Medicare Part A meets the legal requirement for minimum essential coverage. Individuals with Medicare Part A are not eligible to receive premium and cost-sharing assistance (often referred to as advanced payments of the premium tax credit (APTC) or income-based cost sharing reductions (CSRs)) to help pay for a Marketplace plan premium and covered services to make the costs of a Marketplace plan more affordable. Individuals receiving APTC while dually- enrolled in coverage through the a Marketplace and Medicare may have to pay back all or some of the APTC received for months an individual was enrolled in both Marketplace coverage with APTC and Medicare Part A when they file their federal income tax return.

Some people may have had coverage through the Marketplace (and possibly received APTC or CSRs) before being eligible for Medicare. When first eligible for premium-free Medicare Part A, these individuals may have refused or dropped Medicare Part B coverage because the costs for Marketplace coverage, with any financial assistance they may have been receiving, was more affordable than Medicare Part B, and they believed they were eligible for APTC and CSRs. In summer 2016, CMS mailed a notice to Federally-facilitated Marketplace enrollees who were enrolled in Medicare Part A, over age 65 and receiving advanced payments of the premium tax credit informing them of their dual enrollment, loss of eligibility for the tax credits and encouraging them to follow the instructions listed on their notice to either end their APTC or drop their Marketplace coverage and enroll in Medicare Parts A and B.

In addition, some people with Medicare Part A coverage may have enrolled in coverage through the Marketplace believing it was an alternative way to get medical coverage equivalent to Medicare Part B at a more affordable cost. These individuals may not have found

out they were not eligible for APTCs or CSRs or not learned about the coverage rules prior to the end of their Medicare Initial Enrollment Period (IEP), resulting in them either 1) declining to enroll in Medicare Part B at all; or 2) enrolling in Medicare Part B during the General Enrollment Period (GEP) and being assessed a Medicare Part B late enrollment penalty.

CMS believes that many of these individuals did not receive the information necessary at the time of their Medicare IEP or initial enrollment in coverage through the Marketplace to make an informed decision regarding their Medicare Part B enrollment.

Q2. What is the equitable relief?

CMS is offering equitable relief to certain individuals enrolled in both Medicare Part A and coverage through the Marketplace for individuals and families to enroll in Medicare Part B without penalty. Further, CMS is offering equitable relief to certain individuals who dropped or lost their coverage through the Marketplace and are paying a late enrollment penalty from their subsequent late enrollment into Medicare Part B. These eligible individuals can have their penalty reduced. Individuals can apply for the Medicare Part B enrollment opportunity and reduction in late enrollment penalties during a limited time – it is available now and ends September 30, 2017.

Q3. Who is eligible for the equitable relief?

This offer of equitable relief is limited to individuals who currently are or were enrolled in coverage through the Marketplace for individuals and families and are entitled to Medicare premium-free Part A. In addition, to be eligible for the equitable relief, the individual must:

- Have an IEP that began April 1, 2013 or later; or
- Have been notified of a retroactive premium-free Medicare Part A award on October 1, 2013 or later.

To be eligible for the opportunity to enroll in Medicare Part B, the individual must currently have premium-free Medicare Part A and not be enrolled in Medicare Part B. To be eligible for the penalty reduction, the individual must have been assessed a Medicare Part B late enrollment penalty from enrolling in the 2015, 2016 or 2017 GEP. In many instances, the penalty will be eliminated rather than reduced.

Individuals must request the equitable relief and provide documentation showing enrollment in coverage through the Marketplace for individuals and families. Only individuals who are eligible for Medicare can enroll in Medicare.

Notes:

- Individuals who received the CMS notice in summer 2016 regarding their dual enrollment may be eligible for this equitable relief, even if they enrolled in the 2017 GEP. The eligibility criteria outlined above must be met.
- Individuals currently in their IEP are not eligible for this equitable relief as they can currently enroll in Medicare Part B without a late enrollment penalty. This equitable relief cannot change the Part B coverage start date for individuals currently in their IEP.
- Individuals enrolled in a Marketplace SHOP plan are not eligible for this equitable relief, as they have employer-sponsored group health plan coverage and have a statutory

Medicare special enrollment period (SEP) available to them to obtain Medicare Part B coverage without penalty once the employment or employment-based coverage ends.
Individuals paying a premium for Medicare Part A are not eligible for this equitable relief because they are required by law to also be enrolled in Medicare Part B in order to enroll in premium Part A. These individuals can choose to terminate their premium Medicare Part A coverage and get their coverage through the Marketplace (with advanced payments of the premium tax credit and income-based cost sharing reductions, if eligible for that program).

Q4: Is this equitable relief available to beneficiaries who are or were enrolled in a State-Based Marketplace (SBM)?

Yes, equitable relief is available to individuals enrolled in both Medicare Part A and a Marketplace plan – regardless if the Marketplace is in a Federally-facilitated Marketplace (FFM) or an SBM state.

Q5. Why can't people whose IEP started on or before March 1, 2013 get this equitable relief?
These individuals are not eligible for the equitable relief because the Marketplace (and the APTC and income based CSRs) wasn't available to them during their Medicare IEP nor a factor in their decision to refuse or drop Medicare Part B coverage.

Q6. Is the equitable relief available to people with premium-free Medicare Part A based on age and other reasons, such as disability?

Yes. The basis for an individual getting Medicare is not a criterion for this assistance.

Q7. What type of documentation does the person need to provide?

To be eligible for the equitable relief, individuals must show documentation reflecting their enrollment in a Marketplace plan for individuals and families. Acceptable documentation includes:

- A periodic data match (PDM) notice mailed to dually-enrolled aged beneficiaries (those enrolled in both Medicare and an individual Marketplace plan);
- A Marketplace eligibility determination notice (can be accessed via the consumer's Marketplace Account);
- IRS Form 1095-A that demonstrates months of coverage and/or subsidy amounts;
- Marketplace premium invoices and proof of payment;
- Receipt of premium binder payment effectuating Marketplace enrollment; or
- Other documentation that clearly reflects the person was enrolled in a Marketplace plan for individuals and families.

Q8. How long is the equitable relief available?

The equitable relief is available now through September 30, 2017. To be eligible for the relief, individuals must request it by September 30, 2017.

As of this date, the necessary information for individuals to make informed decisions regarding coverage through the Marketplace and Medicare Part B enrollment will be available to new and

current Medicare beneficiaries. The necessary information will be included in the IEP packages (mailed to all individuals automatically enrolled in the Medicare program), GEP packages (mailed to all individuals who refuse or lost Medicare Part B coverage in the last year), the Medicare & You Handbook, and on the Federally-facilitated Marketplace application.

Q9. If someone enrolls in Part B through this equitable relief, when will coverage begin?

For most individuals, Medicare Part B coverage will begin the month the individual enrolls. To ensure there are no gaps in coverage, we encourage individuals to enroll in Medicare Part B using this equitable relief first, and continue Marketplace coverage until they are notified of their confirmed Part B enrollment.

Some people who received the CMS notice in summer 2016 dropped their APTC, but remained in coverage through the Marketplace. These individuals may have found their Marketplace plan premiums unaffordable without that premium tax credit assistance and may have been terminated from their Marketplace coverage for non-payment of premiums. Per Marketplace disenrollment rules, these individuals could lose their Marketplace coverage with up to two months of retroactivity. Thus, those individuals have the option to request that Medicare Part B coverage start two months back from when they complete their request.

Premiums must be paid for all months of Medicare Part B coverage, even if retroactive.

Q10. Will people be notified of the availability of equitable relief?

CMS is mailing a notice in late February to individuals enrolled in both Medicare Part A and Federally-facilitated Marketplace coverage. The notice will include the offer of equitable relief, so that these individuals can enroll in Medicare Part B without penalty. Go to https://marketplace.cms.gov/applications-and-forms/notices.html and scroll to the section called "Periodic Data Matching Notices" for a sample of the February notice.

Individuals who already terminated their Marketplace coverage and enrolled in Medicare Part B with a late enrollment penalty will not be notified of the offer for equitable relief at this time. However, equitable relief is available to this population as well. This fact sheet will be available on CMS' Medicare and Marketplace webpage.

Q11. What should people do to take advantage of this equitable relief?

Individuals who were notified or believe they are eligible for the equitable relief should contact Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit their local Social Security office and request to take advantage of the equitable relief. They can ask for "equitable relief" when they make their request for Medicare Part B enrollment or penalty reduction. Individuals should mention that they were dually enrolled in Medicare premium-free Part A and a Marketplace plan, and provide the information listed above.

Individuals requesting to enroll in Medicare Part B should complete a Medicare Part B enrollment form (Form CMS-40B) available online for download on Medicare.gov, CMS.gov and SSA.gov. They can complete this form and take it to Social Security with them when they request the equitable relief.

Individuals requesting a Medicare Part B penalty reduction should mention this equitable

relief when they contact Social Security.

ALL individuals must bring their documentation of Marketplace enrollment and provide it to Social Security when making their request.

To request this equitable relief, individuals can:

- Call SSA at 1-800-772-1213 (TTY users should call 1-800-325-0778); or
- Visit SSA.gov to find a local Social Security office

Q12. Will people who drop Marketplace coverage or enroll in Part B get a special enrollment period (SEP) to enroll in Part C or Part D?

Yes. Individuals enrolled in premium-free Medicare Part A and coverage through the Marketplace for individuals and families will have an SEP to enroll in a Medicare Advantage plan (with or without prescription drug coverage) when they are notified by SSA confirming their Medicare Part B enrollment. Because the equitable relief provides for an effective date to be the month of application or retroactive up to two months, notification of the Medicare Part B enrollment will occur after the Medicare Part B coverage starts. As such, this SEP begins the month the individual receives notice of the Medicare Part B enrollment confirmation and ends two months later. The effective date of coverage for this SEP depends on the individual's situation, but it may be retroactive back to the first day of the month in which the individual received the notice from SSA.

Individuals who decide not to enroll in a Medicare Advantage plan with prescription drug coverage should enroll in a stand-alone Medicare Part D plan if they don't have another form of creditable prescription drug coverage. Individuals also have an SEP to enroll in Part D. The SEP begins the month in which the Marketplace coverage terminates and ends two months later. The effective date of coverage for this SEP is the first of the month after the plan receives the enrollment request.

Prescription drug coverage offered by Marketplace plans may be considered creditable coverage. Individuals should verify whether the coverage they have through their Marketplace plan is creditable. If the Marketplace plan coverage is creditable, individuals should include their dates of coverage under the Marketplace plan as creditable coverage, if asked by the plan, so that the months the person had prescription drug coverage in the Marketplace are not counted towards any possible assessment of a Part D late enrollment penalty.

As individuals will be assessed a Part D late enrollment penalty if they go without Part D or other creditable coverage for 63 days or more, we encourage individuals to enroll in a Part D plan (either a stand-alone Part D plan or a Medicare health plan with Part D coverage) as soon as they drop their coverage through the Marketplace.

To find Medicare health and prescription drug plans offered in your area, visit Medicare.gov/find-a-plan.

Q13. How can I help?

CMS encourages SHIPs and Marketplace Navigators to share the availability of this equitable relief with Medicare-eligible individuals you assist who are also enrolled in a coverage through the Marketplace.

To help, you can:

- Make eligible individuals aware of this equitable relief;
- Provide the information they need to bring with them to make their request;
- Explain the implications of being dually enrolled in Medicare and Marketplace coverage for individuals and families, including the loss of eligibility for premium tax credits, tax liability, limited times for Medicare Part B enrollment and the Medicare Part B late enrollment penalty;
- Advise individuals with Medicare (and those soon to be eligible) of the ineligibility to get the tax premium and cost-sharing assistance once Medicare Part A begins;
- Encourage individuals with Medicare premium-free Part A to enroll in Medicare Part B;
- Remind individuals to enroll in Medicare Part D if they do not have another form of creditable coverage; and
- Advise individuals soon to be eligible for Medicare of the need to drop coverage through the Marketplace and enroll in Medicare during their IEP.

All these items will help individuals make informed decisions regarding their healthcare coverage.

For more information:

- Go to https://marketplace.cms.gov/applications-and-forms/notices.html and scroll to the section called "Periodic Data Matching Notices" for a sample of the notice.
- See examples of other documentation to show enrollment in the Marketplace for individuals and families.

###

Tax Season Spotlight: Marketplace Call Center vs. the IRS / Choose the Right Tax Preparer

Marketplace Call Center vs. the IRS – Where to Refer Consumers with Tax-Related Questions

The chart below provides a reference for 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.

Marketplace Call Center will handle questions regarding:	Internal Revenue Service will handle questions regarding:

• Form 1095-A (Advance Premium Tax Credit)
• Form 8962 (Premium Tax Credit) and how it works with Form 1095-A
• Advance Premium Tax Credit versus Premium Tax Credit
• Eligibility for Advance Premium Tax Credit
• Exemptions (including who qualifies for exemptions, what to do if your exemption is pending, and how to get an Exemption Certificate Numbers (ECNs))
• Handling problems with Form 1095-A (including missing or incorrect information and duplicate copies)
• How the Tax Credit may Impact Consumers' Tax Refunds
• Fees for Not Having Coverage (what it is, how much it will cost, and what it will be in future years)
• Tax Assistance (including free file, which forms to fill out, where to get assistance with tax filing, and what the tax deadline is)
	• Help Filing Taxes
	• Help Paying Taxes Owed to the IRS
	• Questions Related to Tax Filing, such as:
	  ○ How long can I delay filing?
	  ○ What happens if I don't file?
	  ○ I filed my taxes prior to getting Form 1095-A. How do I amend my tax return?
	• Questions on how to complete Form 8962 Premium Tax Credit
	• Questions on how to complete Form 8965 Exemptions
	• Questions about other tax forms

Tax Season Spotlight: Things to Remember When Choosing a Tax Preparer

Taxpayers should choose their tax return preparer wisely – with good reason. Taxpayers are responsible for all the information on their income tax return. That's true no matter who prepares the return. Here are ten tax tips to keep in mind:

1. **Check the Preparer's Qualifications.** Use the IRS Directory of Federal Tax Return Preparers with Credentials and Select Qualifications. This tool helps taxpayers find a tax return preparer with the qualifications that they prefer. The Directory is a searchable and sortable listing of preparers with a credentials or filing season qualifications. It includes the name, city, state and zip code of Attorneys, Certified Public Accountants, Enrolled Agents, Enrolled Retirement Plan Agents, Enrolled Actuaries, Annual Filing Season Program participants. For more information, check the Understanding Tax Return Preparer Credentials and Qualifications page.
2. **Check the Preparer's History.** Ask the Better Business Bureau about the preparer. Check for disciplinary actions and the license status for credentialed preparers. For CPAs, check with the State Board of Accountancy. For attorneys, check with the State Bar Association. For Enrolled Agents, go to IRS.gov and search for "verify enrolled agent status" or check the Directory.
3. **Ask about Service Fees.** Avoid preparers who base fees on a percentage of the refund or who boast bigger refunds than their competition. When inquiring about a preparer's services and fees, don't give them tax documents, Social Security numbers and other information. Some preparers have improperly used this information to file returns without the taxpayer's permission.
4. **Ask to E-file.** Taxpayers should make sure their preparer offers IRS e-file. Paid preparers who do taxes for more than 10 clients generally must file electronically. The IRS has safely processed billions of e-filed tax returns.
5. **Make Sure the Preparer is Available.** Taxpayers may want to contact their preparer after this year's April 18 due date. Avoid fly-by-night preparers.
6. **Provide Records and Receipts.** Good preparers will ask to see a taxpayer's records and receipts. They'll ask questions to figure the total income, tax deductions, credits, etc.

Taxpayers should not use a preparer who will e-file their return using their last pay stub instead of a Form W-2. This is against IRS e-file rules.

7. **Never Sign a Blank Return.** Don't use a tax preparer who asks a taxpayer to sign a blank tax form.
8. **Review Before Signing.** Before signing a tax return, review it. Ask questions if something is not clear. Taxpayers should feel comfortable with the accuracy of their return before they sign it. They should also make sure that their refund goes directly to them – not to the preparer's bank account. Review the routing and bank account number on the completed return.
9. **Ensure the Preparer Signs and Includes Their PTIN.** All paid tax preparers must have a Preparer Tax Identification Number (PTIN). By law, paid preparers must sign returns and include their PTIN.
10. **Report Abusive Tax Preparers to the IRS.** Most tax return preparers are honest and provide great service to their clients. However, some preparers are dishonest. Report abusive tax preparers and suspected tax fraud to the IRS. Use Form 14157, Complaint: Tax Return Preparer. If a taxpayer suspects a tax preparer filed or changed their return without the taxpayer's consent, they should file Form 14157-A, Return Preparer Fraud or Misconduct Affidavit. Taxpayers can get these forms on IRS.gov any time.

###

Affordable Care Act Reports: Uninsured Rates / Health Outcomes

Uninsured Rates Drop to an All Time Low

The 2016 National Health Interview Survey found that uninsured rates have dipped to a historically low rate (8.8%). To find statistics by demographic, trends and other information, click here.

Surveillance for Health Care Access and Health Services Use

The Behavioral Risk Factor Surveillance System (BRFSS) provides state-level data on health care access and use of clinical preventive services (CPS) that can be used by state health departments, health care organizations, and policymakers. BRFSS has recently released a report highlighting findings from the 2014 BRFSS on health care access and use of preventive health services during the first year that many of the main provisions of the ACA were implemented. The survey finds that adults who had been uninsured or who had inadequate coverage might experience improved access to health care, preventive health services and other health care, and, as a result, better health outcomes.

###

Tips on Direct to Consumer Outreach

Outreach and education are key parts of your role as an assister and are crucial to helping consumers learn about and gain access to affordable, quality health coverage. Make use of the direct to consumer outreach best practices and resources below to evaluate and improve your organizations outreach.

Direct to Consumers Outreach and Enrollment Options

- Door-to-door outreach and direct phone calls can encourage in-depth conversations about consumers' options.

- Brochures and other informational materials about the Marketplace offer a quick guide to important concepts.
- Social media posts advertise services and prompt consumers to investigate more.
- Posters, fact sheets, fliers, postcards, and videos are quick and easy communication projects that you can create yourself.

Direct Outreach Resources

- Review the Dos and Don'ts for Outreach and Education Assistance Activities in Federally-facilitated and State Partnership Marketplaces
- Learn the Tips for Assisters on Working with Outside Organizations
- Use the CMS presentation, Engaging Consumers in the Health Insurance Marketplace as a quick guide to reaching consumers effectively. The tips in this presentation are based on best practices and recommendations received from assisters nationwide.
- Customize the resources found on the Tools & Toolkits section of Marketplace.cms.gov, including flyers, postcards, and other outreach and education materials, based on your organizations needs and outreach goals.
- The Health Insurance Marketplace DIY Design Toolkit has templates with Marketplace logos for you to use – just add content and you are ready to go!

Things to Remember

- Remember that it's against Federal law to place outreach or educational materials directly into a consumer's mailbox.
- Do not call consumers using an automatic telephone dialing system or a prerecorded voice (frequently referred to as autodial or robo-calls) unless the consumer already has a relationship with you or your organization.
- Remember that if a consumer gives you their contact information, like a contact card, this is considered consent by the consumer for future contact as long as the consumer was clearly made aware that the information might be used for future contact. In this case, follow-up contact with the consumer is permitted.

Best Practices When Engaging Consumers in the Health Insurance Marketplace

- Target Your Audience
- Focus on the 2 E's – Educate and Enroll
- Be Inclusive
- Emphasize Affordability
- Keep It Simple
- Keep the Door Open
- Persistence With Permission
- Share Feedback
- Stay Up-to-Date

Best Practices When Contacting Consumers via Email

- Keep email body copy short and direct
- Highlight the benefits available through coverage
- Feature a simple status table showing where the consumer is in the enrollment or re-enrollment process
- Frame re-enrollment as "renewing" coverage
- Provide a graphic or screenshot
- Include contact information
- Use exclamation points (!) and emojis sparingly

Best Practices When Contacting Consumers via Automatic Telephone Dialing Systems (Autodial)

- Understand the importance of autodial
- Consider your audience
- Target your autodial
- Have a clear introduction (name, business name, purpose of call, etc.)
- Keep message shorter than 60 seconds
- Include contact information

###

Help Women #GetCovered during Women's History Month

March is Women's History Month, a time to join in commemorating and advancing the study, observance, and celebration of the vital role of women in American history. To make the most of this period of special recognition for women, Assisters are encouraged to plan outreach events focused on connecting mothers, daughters, and sisters in your community to health care coverage. Consider collaborating with local and state-wide organizations that promote women's health and learn more about community partnerships, collaborations, and referrals, by reading Tips for Assisters on Working with Outside Organizations. Assisters can play an important role in improving women's health nationally by helping consumers' #GetCovered and #StayCovered!

Becoming familiar with the various benefits afforded to women through health care coverage, as well as, general knowledge about gender-specific health concerns can help make outreach in an assister's community even more effective. For example, because women tend to live longer than their male counterparts and will utilize additional health services and pharmaceuticals throughout a lifetime, getting covered is especially important for women. Knowing that health insurance safeguards women from emergencies and provides them access to services that promote their health and wellbeing, such as annual well-woman visits and other preventive care services, is impactful information when educating consumers about the value of health coverage.

As assister can use the women's health resources below to shape messaging when crafting your own outreach and education materials:

Marketplace.CMS.gov Materials

- Use the gender-specific factsheet Need health coverage? The Health Insurance Marketplace is the Place for You in your outreach to women.
- Share the Checklist to Keep Women Healthier with women who enroll in health insurance. The checklist can help those who are new to insurance talk with their doctor or health care provider and find out what preventative services they might need.
- Remember that women are often the major decision-makers on health issues for their family. Be aware of women's specific health care needs and those of families. Mothers can be effective messengers to their uninsured children about the importance of coverage. Learn more here.

Healthcare.gov Materials

Women have rights and protections in the Health Insurance Marketplace!

- A woman won't be charged more for health insurance just because she's a woman.
- Women can't be denied coverage or charged more due to pre-existing conditions, like cancer or being pregnant.
- Women can choose from any primary care provider, OB-GYN, or pediatrician in a health plan's network without a referral.
- Women can access preventive care like mammograms, well-woman visits, contraception, and more.
- And remember, the Marketplace covers essential health benefits and may lower the cost of coverage for men AND women.

HHS Office of Women's Health Materials

Bolster your efforts by learning more about the initiatives' of the HHS Office of Women's Health (OWH) and conduct outreach that coincides with upcoming women's health awareness campaigns. Mark your calendars!

- On March 10, get involved in activities planned for your region on National Women and Girls HIV/AIDS Awareness Day (NWGHAAD). For a list of activities, please contact the Regional Women's Health Coordinator in your region. You can support NWGHAAD now by donating a tweet, Facebook post, or Tumblr post through Thunderclap.
- Gear up for National Women's Health Week (NWHW), which occurs from May 14 – 20. A toolkit with sample social media messages, as well as sample newsletter, blog, and website text will be available this spring. This will not be available online, but if you're interested in receiving the toolkit when it's available, please email Cheryl Thompson (Cheryl.Thompson@hhs.gov).
- For more updates on OWH initiatives and activities, follow OWH on Twitter.

###

Combat Diabetes through Consumer Outreach and Education on American Diabetes Alert Day

This year, American Diabetes Alert Day falls on March 28th and it's the perfect time to conduct consumer outreach and education about the importance of health insurance coverage. Assisters are encouraged to plan outreach events coinciding with American Diabetes Alert Day, the day dedicated to raising awareness about type 2 diabetes, its risk factors, and its prevention. Assisters should consider partnering with health care providers or hospitals/health centers on an American Diabetes Alert Day outreach event, or they can collaborate with local or state chapters of the American Diabetes Association. Learn more about community partnerships, collaborations, and referrals, by reading Tips for Assisters on Working with Outside Organizations.

Assisters can sound the alarm about the prevalence of type 2 diabetes in American adults and share information about health care screening services that allow consumers to learn if they are at risk. Unfortunately, 9 out of 10 Americans most at risk for type 2 diabetes don't know it. And, knowing your risk is the first step toward a healthier life. The good news is that type 2 diabetes, which accounts for 90%–95% of all diabetes cases in the United States, can be prevented or delayed through lifestyle changes such as losing weight and increasing physical activity.

Information about type 2 diabetes and the ways to prevent it is available from numerous sources. Access the American Diabetes Alert Day materials below to jump-start your March 28th #GetCovered outreach!

American Diabetes Association Materials

- Learn all about American Diabetes Alert Day.
- Find your local or state chapter of the American Diabetes Association.
- Discover the American Diabetes Association's Stop Diabetes campaign, a movement to end the devastating toll that diabetes takes on the lives of millions of individuals and families across our nation.

Centers for Disease Control and Prevention (CDC) Materials

Visit the CDC Diabetes Homepage to find out about various initiatives on diabetes control and prevention.

- The CDC-led National Diabetes Prevention Program is working with partners in communities across the United States to establish effective lifestyle change programs for persons at high risk for type 2 diabetes. Lifestyle change programs are listed by state.
- The Just One Step tool created by the National Diabetes Education Program, a joint program of the CDC and the National Institutes of Health, provides helpful tips for making lifestyle changes.
- CDC's Diabetes Interactive Atlases provides data on trends in diagnosed diabetes (both prevalence and incidence), obesity, and leisure-time physical inactivity in the United States.

###

Reaching African American Consumers

African American History Month occurs every February and is a time when our country recognizes the generations of African Americans who struggled with adversity to achieve full citizenship in

American society. In follow-up to African American History Month celebrations, consider how best to organize an outreach event to help African American consumers in your community #GetCovered. Keep in mind that health care access is especially important for African American consumers, who often have higher rates of serious disease than other groups of Americans.

Before the Marketplace opened in 2014, more than 22% of African Americans were uninsured. With the Marketplace, that rate dropped by more than 50 percent—from 22.4% to 10.6%—by early 2016, which was the result of about 3 million non-elderly African American adults gaining coverage. There's still a great need for coverage to reduce the high incidence of certain diseases among African Americans, like high blood pressure, prostate cancer and glaucoma.

To help jump-start Assister #GetCovered outreach, education, and enrollment efforts, make use of the strategies and helpful information linked below with respect to engaging African American consumers.

- According to the Pew Center's National Survey the largest concentrations of faith-based congregations in the African American community are represented in the Christian, Jehovah's Witness, and Islamic denominations.
- Partner with the best messengers in the African American community: faith leaders, doctors, or someone else trusted in the community that has been through the process of enrolling in health insurance and knows how it works. Learn more about community partnerships, collaborations, and referrals, by reading Tips for Assisters on Working with Outside Organizations.
- Use targeted resources for engaging African-American communities, like this Marketplace factsheet on why coverage is important.
- Learn more about Federal government initiatives and programs aimed at improving the health of racial and ethnic minority populations, such as African Americans, by visiting the U.S. Department of Health and Human Services (HHS) Office of Minority Health website.
- Remember that while some think the issue of legal status is one that affects only Latino and Asian American communities, families consisting of foreign-born individuals of African descent also have interest in understanding their eligibility for health care coverage.

###

Combat Cardiovascular Disease by Helping Consumers #GetCovered

February was American Heart Month and although heart disease risk factors can be prevented or controlled, heart disease is still the leading cause of death for both men and women in the United States. Every year, one in four American deaths are caused by heart disease. Nearly half of all Americans have at least one risk factor for heart disease, such as high blood pressure, obesity, physical inactivity, or an unhealthy diet. And, risk also increases with age.

The good news is that Americans of all ages can reduce their risk for heart disease by making simple lifestyle changes (such as eating healthy foods, exercising regularly, and abstaining from smoking) and by managing medical conditions through appropriate treatment plans. That's why spreading messages about prevention and treatment are so important. Keeping one's heart healthy can help in avoiding serious complications, such as heart disease, heart attacks and heart failure.

Assisters can play an important role in the nation's fight against cardiovascular disease, by helping consumers' #GetCovered! Our country recognizes American Heart Month every February and Assister's can continue the momentum of this national effort, by taking time to learn about the risks of heart disease and partnering with organizations in your community (such as your local hospital, health clinic, sport/exercise club, and your state or local chapter of the American Heart Association) for heart healthy outreach events. Learn more about community partnerships, collaborations, and referrals, by reading Tips for Assisters on Working with Outside Organizations.

For more information on American Heart Month campaigns and follow-up actions you can take, including key facts on heart disease risk factors and prevention, visit the Centers for Disease Control and Prevention (CDC) and Food & Drug Administration (FDA) resources listed below:

- Heart Disease Information Webpage
- Million Hearts® for Health Professionals
- Million Hearts® American Heart Month 2017: Change Starts with a Heart-to-Heart
- Strong Men Put Their Heart Health First
- Lower Your Risk for the Number 1 Killer of Women
- Heart Health for Women
- Research on Heart Disease in Women

###

Helping Millennials #GetCovered

Young adults ages 18 to 34 had the highest uninsured rates before the passage of the healthcare law and have seen the sharpest drop in uninsured rates since 2010. Despite these statistics, millions of young adults remain uninsured, showing that there is more work to do to equip young Americans with the tools and information they need to access coverage through the Health Insurance Marketplace. This is noteworthy, since this age group—the Millennials—make up 30 percent of our nation's population.

Spread the word about health coverage to uninsured young adults in your community by targeting outreach to this population where they LIVE, WORK, and STUDY. Two and four year colleges and universities can be great partners for assisters when endeavoring to maximize outreach to young adults. Let the educational campuses in your community know that you're #HereToHelp!

Consider partnering with your local colleges and universities to help Millennials #GetCovered and #StayCovered. The Marketplace.CMS.Gov resources below can help you jump-start young adult outreach:

- 3 Reasons Young Adults Need Health Coverage

  English | Spanish

- What Do I Need to Know About the Marketplace?

  English | Spanish
- Marketplace for College Graduates

  English
- Turning 26?

  English
- Get Covered: A One-Page Guide to the Health Insurance Marketplace

  English | Spanish
- Know Your Rights

  English
- Report Life Changes to the Marketplace After You Enroll in Coverage

  English
- Report Changes (postcard)

  English | Spanish

###

1095-A Correction FAQs for Tax Year 2015 and 2016

Consumers who enrolled in Marketplace coverage should receive a Form 1095-A, Health Insurance Marketplace Statement, by January 31 of the year following the year of coverage. For instance, consumers who enrolled in coverage through the Marketplace in 2016 should have received a Form 1095-A by January 31, 2017. Consumers should use the information on the form to claim the premium tax credit, or reconcile advance payments of the premium tax credit, or both, when filing their tax returns. However, some consumers may receive a second Form 1095-A because the information on the initial form was incorrect or incomplete. Below are some frequently asked questions related to Form 1095-A corrections.

Q1: What should a consumer do if he or she received an incorrect for 1095-A?

A1: If a consumer identifies errors or has questions about his or her form, the consumer should contact the Federally-facilitated Marketplace call center at 1-800-318-2596.

Q2: How does a consumer know if he or she received a corrected Form 1095-A, and why is it important?

A2: If a consumer received a Form 1095-A with the "CORRECTED" box checked at the top, it generally means that the consumer previously received a Form 1095-A containing one or more errors.

Q3: How should a consumer use the corrected Form 1095-A?

A3:

- If the consumer has not yet filed his or her tax return, the consumer should use this new form when completing his or her tax return.
- If the consumer already filed his or her tax return, the consumer will need to determine the effect that the changes in his or her corrected form might have on the return. Some changes may not affect the consumer's tax return or require any action on the consumer's part, while others might. Compare the corrected Form 1095-A to the original form to determine the nature of the change. The information in Q&A 4 below can help consumers assess whether he or she should file an amended tax return, Form 1040X. If a consumer is uncertain whether he or she should amend the tax return, he or she may want to consult with a tax preparer.

If the consumer believes the information on his or her corrected Form 1095-A is incorrect, the consumer should contact the Marketplace immediately to receive an accurate Form 1095-A.

Q4: What changes could a consumer see on his or her new Form 1095-A that will likely affect the consumer's tax return?

A4:

- The number of individuals covered, or their ages, in Part II of the form.
- Monthly premiums for the consumer's plan in Part III of the form.
- Amount of the consumer's second lowest cost Silver plan premium listed in Part III of the form.
- Advance payments of the premium tax credit in Part III of the form.
- Months for which the consumer had coverage in Part III of the form.

If any of these changes appear on the consumer's new Form 1095-A, he or she may need to file an amended tax return, Form 1040X. The consumer may want to consult with a tax preparer to determine if he or she needs to file an amended return.

Q5: What changes could a consumer see on his or her new Form 1095-A that likely will not affect the consumer's tax return?

A5:

- The consumer's name, social security number, and other identifying information in Part I of the form.
- The names and social security numbers of covered individuals in Part II of the form.

If either of these changes appear on the consumer's new Form 1095-A but the form contains none of the changes in the list included in Q&A 4 above, he or she likely does not need to file an amended return.

Q6: What should a consumer do if he or she received a voided Form 1095-A?

A6: If a consumer receives a Form 1095-A with the "VOID" box checked at the top, or if the consumer received a letter from the Marketplace indicating that he or she should disregard the Form 1095-A, it generally means that the consumer previously received a Form 1095-A that was issued in error. This may happen if the consumer did not complete enrollment in Marketplace coverage.

The voided Form 1095-A – as the well as the previously received Form 1095-A – should not be used to file the consumers tax return.

- If the consumer received a voided Form 1095-A after he or she has already filed the tax return and claimed the premium tax credit using the original Form 1095-A that the Marketplace sent in error, the consumer should file an amended return.
- If the consumer has not yet filed his or her tax return, he or she should not use the information on the voided Form 1095-A or on the previously received Form 1095-A to claim a premium tax credit on Form 8962.
- If the consumer had coverage through the Marketplace and the consumer believes he or she should not have received a voided form, the consumer should contact the Marketplace immediately to receive an accurate Form 1095-A.

Additional Information

- If a consumer did not receive advance payments of the premium tax credit and he or she is not eligible for this credit, changes to his or her Form 1095-A would not affect his or her tax return.
- See the IRS' Question and Answers about Health Care Information Forms for Individuals.
- Additional Amended Return Information
- Below is a link for information on corrected 1095-A forms.

  https://www.irs.gov/affordable-care-act/corrected-incorrect-or-voided-forms-1095a-for-tax-years-2014-2015-and-2016

###

Health Coverage Tax Tool

The health coverage tax tool gives consumers information needed to file their tax returns. The tool will help a consumer:

1. *Determine his or her premium tax credit* by providing accurate information about the consumer's "second lowest cost Silver plan" (SLCSP). Consumers will use this information to fill out IRS Form 8962, Premium Tax Credit, and determine his or her premium tax credit amount.
2. *Claim an "affordability" exemption*. If a consumer did not have health coverage because he or she could not afford it, the consumer may not have to pay a penalty. This tool will provide information the consumer needs, including the price of the lowest cost Bronze plan, to claim an affordability exemption from the penalty. A consumer can use it to fill out IRS Form 8965, Health Coverage Exemptions.

Below are some frequently asked questions about the Health Coverage Tax Tool:

Q1: Do all consumers need to use this tool?

A1: No, consumers with correct information about their SLCSP in Part III, column C of their Form 1095-A do not need to use this tax tool.

Q2: When should a consumer use this tool?

A2: A consumer may need to use this tool only if one of the following applies to the information in Part III, column C of his or her Form 1095-A:

- It does not include information about the consumer's SLCSP premium.
- The information about the consumer's SLCSP premium is incorrect or incomplete.

This could be the case if:

- The consumer had a change to his or her household in 2016 that the consumer didn't report to the Marketplace — like having a baby, moving to a new home, a tax dependent changing status, or a family member getting job-based coverage.
- The consumer did not apply for financial assistance when he or she filled out the 2016 Marketplace application, and now wants to find out if he or she qualifies.
- The consumer did not take advance payments of the premium tax credit to lower the amount he or she paid for monthly premiums in 2016,

Q3: What information is needed to use the tool?

A3: The coverage tool requires:

- The ZIP code and county where the consumer and each covered family member lived each month of 2016 while enrolled in a Marketplace plan.
- The birthdate of each family member covered.
- The months each family member was enrolled in Marketplace coverage and was not eligible for other health coverage.

Q4: Who is considered a covered family member?

A4: The consumer's coverage family consists of any individual who:

1. The consumer will claim as a personal exemption on his or her tax return,
2. Was enrolled in Marketplace coverage; and,
3. Was not eligible for coverage outside of the Marketplace (i.e. Medicaid, Medicare or job based coverage) for at least one month of the year.

Q5. Who should the consumer select as Family Member #1 in the tax tool?

A5. In order for the tool to provide accurate results, it is important to choose the correct family member as the first family member you enter into the tool, or Family member #1.

Family member #1 is generally

- the person who was *enrolled in Marketplace coverage* in 2016,
- *not eligible for coverage outside the Marketplace*, and
- *who will file* a 2016 tax return claiming a personal exemption for himself or herself and the coverage family (for a married couple filing a joint return who were both enrolled and not eligible for coverage outside the Marketplace, either spouse may be Family member #1).

If no one in the coverage family meets these three criteria, the consumers should use the following rules:

1. If only one person was in the consumer's coverage family in 2016, he or she is Family member 1.
2. If more than one person was in the consumer's coverage family, choose as Family member 1 one of the family members who lived with the consumer in 2016. If none of the coverage family members lived with the consumer, the oldest coverage family member is Family member 1.

For more information, go to https://www.healthcare.gov/tax-tool/

###

NEW Summary of Webinar presentation on "Marketplace Eligibility Appeals"

The Friday, February 3, 2017 assister webinar included a presentation on the Marketplace eligibility appeals process. Once consumers apply for coverage in the Marketplace, the consumer will get an eligibility notice that explains what he or she qualifies for. If a consumer does not agree with a decision made by the Health Insurance Marketplace, he or she may be eligible to file an appeal.

Here are some highlights from the presentation:

When can a consumer file a Marketplace appeal?

Consumers have 90 days from the date they receive their eligibility notice to start an appeal.

What kinds of Marketplace decisions can consumers appeal?

Whether he or she is eligible to buy a Marketplace plan.

Whether he or she can enroll in a Marketplace plan outside the regular Open Enrollment Period.

Whether he or she is eligible for lower costs based on his or her income.

The amount of savings for which he or she is eligible.

Whether he or she is eligible for Medicaid or the Children's Health Insurance Program (CHIP).

Whether he or she is eligible for an exemption from the individual responsibility requirement.

How can consumers file a Marketplace eligibility appeal?

Here are the 2 ways consumers can request an appeal:

Consumers may mail in their state's appeals request form or their letter to:

Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061

Consumers may fax an appeal request to this secure fax line: 1-877-369-0129

*Note: Depending on the consumer's state and the consumer's eligibility results, he or she may be able to appeal through the Marketplace. Or **the consumer may have to file an appeal with his or her state Medicaid or CHIP agency**. The letter the consumer receives will explain.

Then what happens?

Once a consumer submits an eligibility appeal, the Marketplace Appeals Center will review the consumers' request. The consumer will get a letter in the mail letting him or her know that the Marketplace has received the appeal. The Marketplace Appeals Center will contact the consumer to discuss the appeal and will work with the consumer to **resolve the appeal informally**. If the consumer has questions about his or her eligibility appeal, advise him or her to call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. If a consumer is not satisfied with the outcome of the informal resolution of his or her eligibility appeal, the consumer has **the right to a hearing**. A hearing is a more formal way for a consumer to present his or her case and get a decision on the appeal. If a consumer wants a hearing, a federal hearing officer will conduct it, usually by phone. The consumer will receive a letter in the mail 15 days before the hearing with the date, time, and instructions on how to call into the hearing. If the consumer does not show up for the hearing, the appeal could be dismissed. If the consumer's appeal is dismissed, it's the same as if the consumer had never filed an appeal, and the consumer's last Marketplace eligibility determination will remain in effect. After the consumer's eligibility appeal is determined, he or she will get a letter in the mail explaining the decision.

If an appeal is urgent, consumers can request an expedited appeal.

A consumer can file a request for an expedited (faster) appeal if the time needed for the standard appeal process would jeopardize the consumer's life or ability to attain, maintain, or regain maximum function.

A consumer's request to expedite an appeal should specifically explain how a standard appeal would jeopardize the consumer's life or his or her ability to attain, maintain, or regain maximum function.

A consumer's request to expedite his or her appeal will be processed as quickly as possible.

The Marketplace can help. A consumer can visit Healthcare.gov here to get more information on how to get help filing an appeal. If a consumer wants to get help in a language other than English, he or she has the right to get help and information about appeals and other Marketplace issues in his or her language at no cost. To talk to an interpreter, a consumer can call 1-800-318-2596.

SHOP Marketplace decisions can also be appealed. A consumer can visit Healthcare.gov here to get more information on how to appeal a SHOP Marketplace decision.

Additional Resources:

- **HealthCare.gov – "How to appeal a Marketplace decision"**
- **Fact sheet and instructions - Appeals: Eligibility & Health Plan Decisions in the Health Insurance Marketplace**

- How to Appeal a Marketplace Decision versus a Health Plan Decision
- Infographic – "Steps for a Marketplace Appeal"

###

NEW Assisting the H-2A Workers Population

The Affordable Care Act (ACA) provides new options to obtain health insurance coverage for individuals who migrate to the United States to perform agricultural labor or services of a temporary or seasonal nature. Every year, between 50,000 and 100,000 foreign workers come to the U.S. to work in agriculture with temporary H-2A visas. These H-2A workers are lawfully present in the U.S. and are therefore subject to certain rights and responsibilities under the ACA. The following frequently asked questions address some of the major provisions of the law that relate to H-2A workers:

What are the obligations of H-2A workers under the ACA?

Because they are lawfully present for the purposes of the ACA, H-2A workers are subject to the minimum essential coverage provision. H-2A workers who do not have health insurance while in the United States and also do not qualify for one of a number of statutory exemptions may be assessed a tax penalty when they file their federal income tax returns.

Are H-2A workers eligible for Medicaid?

No. H-2A workers do not qualify for Medicaid because they are not considered "qualified immigrants under U.S. immigration law." Qualified immigrants include Lawful Permanent Residents who have held this status for more than 5 years, refugees, and asylees, among others. Even in states that have expanded Medicaid to other immigrant categories, H-2A workers are not eligible due to their temporary status.

Is there a deadline for H-2A workers to apply for health insurance?

Yes. H-2A workers must apply for health insurance within 60 days after they have entered the United States. It's also imperative for H2-A workers to cancel their health insurance before they leave the United States.

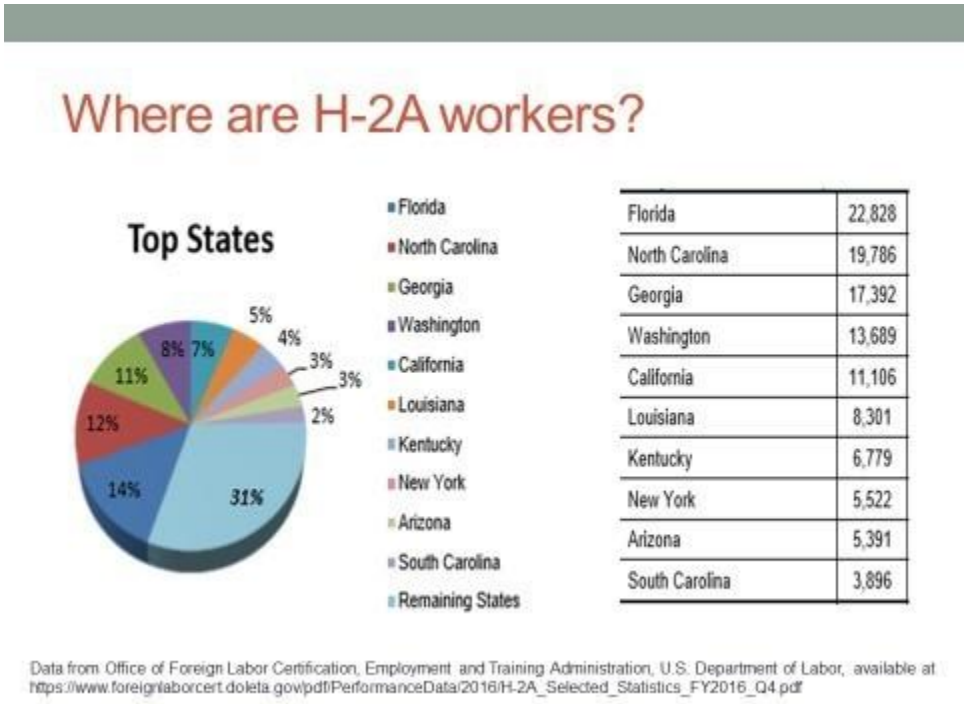
What documentation do H-2A workers need to apply for health insurance?

To apply for health insurance in the Marketplace, H-2A visa holders must provide:

- Passport
- Social Security Card
- Most recent pay stub or W-2 tax form
- Employer's name and address

What are some of the best practices to target this population?

- Partner with employers, community organizations, and others to provide information.
- Make employers aware that H-2A workers are eligible for health insurance under the ACA.
- Ensure sustained on-site in-person assistance.
- Conduct enrollment at times and locations convenient for workers.



Florida	22,828
North Carolina	19,786
Georgia	17,392
Washington	13,689
California	11,106
Louisiana	8,301
Kentucky	6,779
New York	5,522
Arizona	5,391
South Carolina	3,896

Data from Office of Foreign Labor Certification, Employment and Training Administration, U.S. Department of Labor, available at https://www.foreignlaborcert.doleta.gov/pdf/PerformanceData/2016/H-2A_Selected_Statistics_FY2016_Q4.pdf

###

The Draft 2017 Quality Rating System (QRS) and QHP Enrollee Survey Call Letter Is Posted for Comment

The draft 2017 Call Letter for the QRS and the QHP Enrollee Survey is available for comment and can be accessed via CMS' Marketplace Quality Initiatives (MQI) website. The 2017 QRS Call Letter serves to communicate and request comment on CMS' proposed refinements to the QRS and QHP Enrollee Survey programs for QHPs. Based on stakeholder feedback, CMS will finalize any changes and communicate these in the final 2017 Call Letter. The public comment period ends on 3/22/2017.

###

MACRA/Quality Payment Program (QPP) Updates

CMS BLOG - Supporting Comprehensive and Innovative Care for Children: Request for Information on a Potential Pediatric Alternative Payment Model

https://blog.cms.gov/2017/02/27/supporting-comprehensive-and-innovative-care-for-children-request-for-information-on-a-potential-pediatric-alternative-payment-model/

February 27, 2017

By Patrick Conway, M.D., M.Sc., Acting Administrator, Centers for Medicare & Medicaid Services; Deidre Gifford, M.D., M.P.H., Deputy Director, Center for Medicaid and CHIP Services; Ellen-Marie Whelan, N.P., Ph.D., Chief Population Health Officer, Center for Medicaid and CHIP Services; and Alex Billioux, M.D., D.Phil., Director, Division of Population Health Incentives and Infrastructure, Center for Medicare & Medicaid Innovation

Supporting Comprehensive and Innovative Care for Children: Request for Information on a Potential Pediatric Alternative Payment Model

In partnership with states and providers, the Centers for Medicare & Medicaid Services (CMS) plays a leading role in safeguarding the health of America's future by providing coverage for more than one in three American children[1]. Through Medicaid and the Children's Health Insurance Program's (CHIP) mandatory and optional benefits, children receive access to a spectrum of comprehensive and preventive health care services aimed at providing a sound start for lifelong health. As a result, children enrolled in Medicaid and CHIP lead the nation in participation in preventive care and access to needed care[2].

CMS and states have also demonstrated consistent commitment to improving the health of children through care redesign and innovation in programs such as Medicaid Health Homes, the Medicaid Innovation Accelerator Program, and models tested under the Center for Medicare and Medicaid Innovation (Innovation Center), including the State Innovation Models Initiative and Strong Start for Mothers and Newborns Initiative. To build on those efforts, the Innovation Center, in partnership with the Center for Medicaid and Chip Services (CMCS), is releasing a Request for Information (RFI) today seeking input on the design of alternative payment models focused on improving the health of children and youth covered by Medicaid and CHIP. As the insurer of a third of the nation's children and a leader in health care innovation, CMS is uniquely positioned to improve the health of America's children.

We know there is more to health than health care alone, and for children, factors such as sound nutrition, safe living environments, responsive adult caregivers, and nurturing social relationships are especially critical for healthy growth and development. Inadequate or inconsistent access to these factors can have physical and behavioral impacts that reverberate throughout a child's life course as he or she grows into adulthood. Some children and youth enrolled in Medicaid and CHIP, especially those that are high-need and high-risk, may experience barriers to accessing the optimal combination of child-focused programs and services that are available to address these critical factors. Through the RFI, we are seeking input on approaches to improve the quality and reduce the cost of care for children and youth enrolled in Medicaid and CHIP. In particular, we are exploring concepts that encourage pediatric providers to collaborate with health-related social service providers (e.g., early childhood development programs, child welfare services, and

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[1] Department of Health and Human Services. *2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP*. February, 2016. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf

[2] See CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings, available at http://www.mathematica-mpr.com/~/media/publications/pdfs/health/rpt_chipevaluation.pdf; Kreider AR, French B, Aysola J, Saloner B, Noonan KG, Rubin DM. Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families. JAMA Pediatr. 2016;170(1):43-51. doi:10.1001/jamapediatrics.2015.3028

home and community based service providers) at the state and local levels and share accountability for health outcomes for children and youth enrolled in Medicaid and CHIP.

CMS seeks input through the RFI from the broad community of child and youth-focused stakeholders on concepts critical to addressing the comprehensive health needs of children and youth, such as:

- Opportunities and impediments to extending and enhancing integrated service model concepts like accountable care organizations (ACOs) to the pediatric population;
- Flexibilities and supports states and providers may need in order to offer such models of care to a state's pediatric population; and
- Approaches for states and providers to coordinate Medicaid and CHIP benefits and waivers with other health-related social services for children and youth.

Investing in child health can provide lifelong benefits and improve the nation's health. We look forward to front-end comments from our state partners and other stakeholders who share our dedication to improving the health of our nation's children.

For more information on the RFI, please visit: https://innovation.cms.gov/initiatives/pediatric-apm. To be assured consideration, RFI comments must be received by March 28, 2017.

###

CMS Publishes Updated eCQM Table for Eligible Clinicians and Eligible Professionals for 2017 Performance Period

The Centers for Medicare & Medicaid Services (CMS) has published an updated table accompanying the 2016 electronic clinical quality measure (eCQM) specifications (published in April 2016) for the 2017 performance period. The updated table, titled Electronic Clinical Quality Measures for Eligible Professionals and Eligible Clinicians can be found on the eCQM Library Page and the Electronic Clinical Quality Improvement (eCQI) Resource Center.

This update removes the previous meaningful use domains and now aligns with the domains listed in the Calendar Year 2016 Medicare Physician Fee Schedule, as well as the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) tracks of the Quality Payment Program.

Questions regarding the measure table or domains should be reported to the ONC CQM Issue Tracker available at http://jira.oncprojectracking.org/browse/CQM/.

###

Quality Payment Program Short Training Videos Now Available

We have created a number of new, self-paced educational videos that are now available on YouTube (Go.cms.gov/QPPvideos) and our Events page. These videos help to explain aspects of the Quality Payment Program in approximately 10 minutes or less. We think our stakeholders will greatly benefit from this form of on-demand learning that allows them to choose their educational pace.

Quick general overview: What is the Quality Payment Program?

Advanced Payment Models (APMs)

- Introduction to Advanced Alternative Payment Models (APMs)
- What are the criteria for Advanced Alternative Payment Models (APMs)?

- What is a qualifying APM participant?
- What is the APM scoring standard?

Merit-based Incentive Payment System (MIPS)

- Introduction to the Merit-based Incentive Payment System (MIPS)
- Who participates in the Merit-based Incentive Payment System?
- How do eligible clinicians participate in the Merit-based Incentive Payment System?
- The Merit-based Incentive Payment System performance categories
- What is the scoring methodology for the Merit-based Incentive Payment System?

###

View QPP Webinars and CMS' HIMSS17 Presentations on the CMS Website

The Centers for Medicare & Medicaid Services (CMS) recently posted new resources to the Quality Payment Program website to help healthcare professionals participate in the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

CMS was a very active participant at HIMSS 2017; the HIMSS presentations also provide information on the Quality Payment Program and value-based care. Use the links below to access the presentations on each topic.

Webinar Presentations:

- MACRA Quality Payment Program Overview
- APMs in the Quality Payment Program for Shared Savings Programs
- Medicaid in the Quality Payment Program
- Quality Payment Program Final Rule MLN Connects® Call
- MIPS Overview
- MIPS Performance Categories: Advancing Care Information & Improvement Activities
- MIPS Overview: Understanding Quality and Cost
- National Provider Call: Transitioning from Quality Programs to MIPS
- Virtual Groups in the Quality Payment Program
- Getting Started with the Quality Payment Program: An Overview of MIPS for Small, Rural, and Underserved Practices
- MACRA Merit-based Incentive Payment System Annual Call for Measures and Activities

HIMSS17 Presentations:

- Delivery System Reform
- Quality Payment Program Overview
- Advancing Care Information and Improvement Activities
- MIPS: Quality and Cost
- Overview of MIPS for Small, Rural, and Underserved Practices

###

CMS Publishes Updated (eCQM) Table for Eligible Clinicians and Eligible Professionals for 2017 Performance Period

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found on the eCQM Library Page and the Electronic Clinical Quality Improvement (eCQI) Resource Center. This update removes the previous Meaningful Use domains and now aligns with the domains listed in the Calendar Year 2016 Medicare Physician Fee Schedule, the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Quality Payment Program.

Questions regarding the measure table or domains should be reported to the ONC CQM Issue Tracker available at http://jira.oncprojectracking.org/browse/CQM/.

###

Upcoming CMS Webinar - ACO Track 1+ Model

Medicare Accountable Care Organization (ACO) Track 1+ Model Webinar

- **Date:** Wednesday, March 22 **Time:** 2:00 to 3:00 pm ET
- **Registration Link:** Medicare ACO Track 1+ Model Webinar Registration
- **Target Audience:** Existing and prospective Medicare Shared Savings Program ACOs and other program stakeholders interested in the new Medicare ACO Track 1+ Model opportunity.

The webinar is open to the public and will provide an overview of the Medicare ACO Track 1+ Model, including details on the Model's design, eligibility and application requirements, evaluation, and learning activities. The webinar will specify actions ACOs need to take to submit their application this summer for a 2018 start date, and provide the audience the opportunity to ask questions and receive answers from CMS staff. For more information please access the Track 1+ Model detailed Fact Sheet - New Accountable Care Organization Model Opportunity: Medicare ACO Track 1+ Model.

###

View Quality Payment Program Webinars and CMS' HIMSS17 Presentations

The Centers for Medicare & Medicaid Services (CMS) recently posted new resources to the Quality Payment Program website to help healthcare professionals participate in the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

The HIMSS presentations also provide information on the Quality Payment Program and value-based care. Use the links below to access the presentations on each topic.

Webinar Presentations:

- MACRA Quality Payment Program Overview
- APMs in the Quality Payment Program for Shared Savings Programs
- Medicaid in the Quality Payment Program
- Quality Payment Program Final Rule MLN Connects® Call
- MIPS Overview
- MIPS Performance Categories: Advancing Care Information & Improvement Activities
- MIPS Overview: Understanding Quality and Cost
- National Provider Call: Transitioning from Quality Programs to MIPS
- Virtual Groups in the Quality Payment Program

- Getting Started with the Quality Payment Program: An Overview of MIPS for Small, Rural, and Underserved Practices
- MACRA Merit-based Incentive Payment System Annual Call for Measures and Activities

HIMSS17 Presentations:

- Delivery System Reform
- Quality Payment Program Overview
- Advancing Care Information and Improvement Activities
- MIPS: Quality and Cost
- Overview of MIPS for Small, Rural, and Underserved Practices

###

Medicare and Medicaid Updates

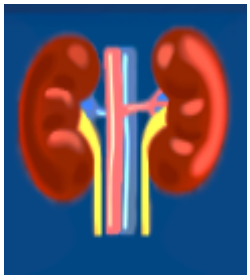
Equitable Relief for Beneficiaries Dually Enrolled in Medicare and Marketplace

CMS is offering assistance to Medicare beneficiaries currently enrolled in Medicare Part A and the Marketplace for individuals or families. This assistance provides eligible individuals with an opportunity to enroll in Medicare Part B without penalty. Further, CMS is offering assistance to eligible individuals who were dually enrolled in Medicare Part A and the Marketplace for individuals and families and subsequently enrolled in Medicare Part B with a penalty. This assistance provides these individuals an opportunity to request a reduction in their Medicare Part B late enrollment penalty.

For more information, click here: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html

###

March is National Kidney Month



1in 3 American adults is at risk for kidney disease. Medicare Part B covers preventive screening tests that help detect diabetes and high blood pressure - 2 conditions that may lead to kidney damage. Visit Medicare.gov/coverage/preventive-and-screening-services.html for more information.

Medicare Part B also covers up to 6 sessions of kidney disease education services if a person has Stage IV chronic kidney disease that will usually require dialysis or a kidney transplant. For more information, visit Medicare.gov/coverage/kidney-disease-edu.html.

###

December 2016 Medicaid and CHIP Application, Eligibility Determination, 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 2016. This report measures eligibility and enrollment activity for the entire Medicaid and CHIP programs in all states , reflecting activity for all populations receiving comprehensive Medicaid and CHIP benefits in all states, including states that have not yet chosen to adopt the new low-income adult group established by the Affordable Care Act.

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

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

###

Medicare Periodic Data Matching (PDM) Notices

The Marketplace will send notices to consumers aged 65 and up that are dually enrolled in both Marketplace plan and Medicare. Consumers will receive a paper notice asking them to return to the Marketplace and follow listed instructions regarding their dual enrollment status to end their Marketplace coverage.

Click here to view the overview and notices (PDF):
English- https://marketplace.cms.gov/applications-and-forms/medicare-pdm-notice-march-2017.pdf
The notice can be found in Spanish here: https://marketplace.cms.gov/applications-and-forms/medicare-pdm-notice-spanish-march-2017.pdf

###

Upcoming Webinars and Events and Other Updates

Medicare Learning Network

News & Announcements

- IRF and LTCH QRP Preview Reports Available: Review by March 30
- March is National Colorectal Cancer Awareness Month
- Social Security Number Removal Initiative: New Details
- Clinical Laboratories: Report Lab Data through March 31

- New Release of PEPPER for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Rerun Your Quality Measure Reports
- LTCHs: Exceptions to Moratorium on Increasing Beds
- Therapeutic Continuous Glucose Monitors Classified as Durable Medical Equipment
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Home Health Care: Proper Certification Required
- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Medicare Diabetes Prevention Program Expanded Model Webinar — March 22
- Medicare ACO Track 1+ Model Webinar — March 22
- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Open Payments: Prepare to Review Reported Data Call — April 13
- Home Health Quality Reporting Program Provider Training — May 3 and 4

Medicare Learning Network Publications & Multimedia

- Critical Access Hospital Booklet — Revised
- Transitional Care Management Services Fact Sheet — Revised
- MREP Software Fact Sheet — Reminder
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Reminder
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder
- Medicare Enrollment Resources Educational Tool — New
- Chronic Care Management Services Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Suite of Products & Resources Educational Tools — Revised
- Federally Qualified Health Center Fact Sheet — Revised
- PECOS for DMEPOS Suppliers Fact Sheet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder
- Advance Care Planning Fact Sheet — Reminder

###

Upcoming CMS Webinar - ACO Track 1+ Model

Medicare Accountable Care Organization (ACO) Track 1+ Model Webinar

- **Date:** Wednesday, March 22 **Time:** 2:00 to 3:00 pm ET

- **Registration Link:** Medicare ACO Track 1+ Model Webinar Registration
- **Target Audience:** Existing and prospective Medicare Shared Savings Program ACOs and other program stakeholders interested in the new Medicare ACO Track 1+ Model opportunity.

The webinar is open to the public and will provide an overview of the Medicare ACO Track 1+ Model, including details on the Model's design, eligibility and application requirements, evaluation, and learning activities. The webinar will specify actions ACOs need to take to submit their application this summer for a 2018 start date, and provide the audience the opportunity to ask questions and receive answers from CMS staff. For more information please access the Track 1+ Model detailed Fact Sheet - New Accountable Care Organization Model Opportunity: Medicare ACO Track 1+ Model.

###

SAVE THE DATE: National Medicare Education Program (NMEP) Webinar

Wednesday, March 29, 2017 1:00 p.m. – 2:30 p.m. EDT Conference Call / Webinar
Registration and agenda coming soon!

###

New Publications On-line

- Agent/Broker Enrollment User Guide
- Welcome to Medicare (Initial Enrollment Period Package)
- Calculating the Late Enrollment Penalty
- Medicare Coverage of Ambulance Services – Spanish
- Withholding Medicare Prescription Drug Premium from your 2017 Social Security Payment - Spanish
- How to Enroll in the Shop Marketplace for Employees – Spanish
- SHOP Employee Enrollment User Guide
- How to Enroll in the SHOP Marketplace for Employers
- SHOP Employer Enrollment User Guide
- Special Enrollment Periods Available to Consumers
- Speaking with a Friend or Family Member's Doctor During an Office Visit

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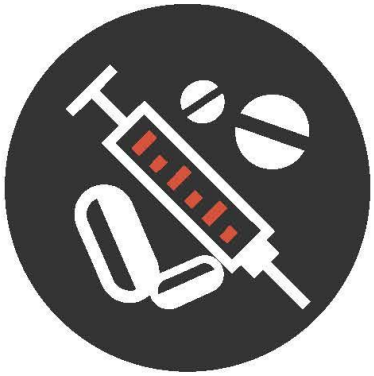
The Opioid Crisis: What Nurses Need to Know!

MISSOURI NURSES ASSOCIATION | KSNA KANSAS STATE NURSES ASSOCIATION | NNA NEBRASKA NURSES ASSOCIATION



CONFERENCE

The Opioid Crisis: What Nurses Need to Know!

March 22, 2017
9:30 a.m. - 4:30 p.m.

Target Audience
RNs and APRNs from a variety of primary and acute care settings who are interested in learning more about the opioid epidemic, including safe opioid prescribing, safe opioid use and options for pain management.

Topics Include
- Federal, State, & Community Response to the Opioid Crisis
- Safe Opioid Prescribing & Project ECHO
- Chronic Pain and Behavioral Health
- Patient Engagement & Education on Safe Opioid Use and Pain Management
- Medication Assisted Treatment (MAT)
- The Nurse's Role in Patient Safety

Location
Richard Bolling Federal Building, Cafeteria Conference Room G64
601 East 12th Street, Kansas City, Missouri 64106

Cost
$89.00

Register
www.missourinurses.org/event/Opioid2017

Accreditation
The Midwest Multistate Division is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Participants are eligible to receive 5.75 contact hours.

Questions
Contact Sara Fry at 573.636.4623 x102 or sara@midwestnurses.org.

MIDWEST MULTISTATE DIVISION

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