CMS Region 7 Updates – 06/16/2017

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2017 CMS Assister Summit

CMS will host a two-day in-person meeting for Marketplace assisters. This interactive event will include in-depth assister training and education on a variety of topics that support Marketplace program integrity and stability.

Join us for a 2-Day Assister Training:

- **June 28, 2017** from 12PM - 5PM EDT; and
- **June 29, 2017** from 9AM - 5PM EDT

Location: CMS Headquarters, 7500 Security Boulevard, Baltimore, MD 21244 or via webcast

Session Topics Include:

- Vision for Assisters in the Evolving Marketplace
- Keeping Consumers Covered
- Data-Driven Outreach
- Overlapping Coverage: Medicare Transitions, Medicaid & the Marketplace
- Special Enrollment Periods: Overview & Verification
- Balancing the Risk Pool
- Assister Best Practices
- Enrollment Troubleshooting

Event Materials: Event materials (i.e., agenda, presentations, Summit Guide, etc.) prior to your arrival to the event — are available in advance here: Certain materials will also be printed and available for in-person attendees.

Assisters are encouraged to submit questions on specific sessions via the survey Ask CMS Questions in Advance by 1PM EST on Sunday, June 18. We plan to address as many questions as possible live during the event.

Registration Information

Important Message: Should on-site registration reach capacity, please note that this event will also be administered virtually via a simultaneous webcast. **Webcast registration will close the day before the Summit on June 27, 2017.**

Please keep in mind of the following:

- Your confirmation is unique to your registration.
- Please do not forward your confirmation to another individual.

There is no cost associated with attending this training.

Webcast Registration:

Webcast registration is open to all. Participants who register in advance will receive a confirmation email with other event details.

Webcast: Click here for webcast registration.

Interpreting and captioning services will be provided.

Issues with Registration:

This event does not require a password. However, if you previously registered and/or attended a CMS webinar training or webcast event using CMS' Adobe Connect, you may be prompted to enter a password associated with your email address.

Password Resets Issues Only:

If you have forgotten your CMS Adobe Connect password, please email webinar@cms.hhs.gov and CTEO@cms.hhs.gov for assistance.

Changes/Cancellations:

If you registered to attend this event in-person and you are unable to attend, we would appreciate being informed of these changes as quickly as possible so that the seat may be given to another participant. Please email us at CTEO@cms.hhs.gov.

Reasonable Accommodations:
It is CMS' sincere desire to comply fully with the Americans with Disabilities Act (ADA) of 1990. We kindly ask attendees that need a reasonable accommodation to notify CMS via email at CTEO@cms.hhs.gov no later than June 16, 2017.

Additional Information: If you have additional questions regarding this event, please contact CMS via email at CTEO@cms.hhs.gov.

Hotel and Travel Information:

Travel and lodging expenses will be the responsibility of the attendee. Baltimore Washington International Airport (BWI) serves as the most convenient airport in the Baltimore, MD area. For airport, ground transportation, car rentals, and shuttle information, please click here. For hotel accommodations, you may lodge in downtown Baltimore or near the BWI airport. If a taxi service is required to and/or from the CMS Headquarters, it is recommended that you schedule your taxi service in advance for drop off and/or pick up. If you plan to drive to the event, free parking will be available at CMS Headquarters. For helpful tips while visiting the Baltimore, MD area, please click here.

Access to CMS Campus

Access to CMS headquarters at 7500 Security Boulevard is granted to authorized personnel only. Vehicle screening is conducted on all modes of transportation. Visitors must have a valid

government issued ID and a reason to be present at CMS. All passengers in the vehicle are subject to these requirements.

Access to the building is granted after proper screening. Once verified, all personal belongings (including purses, briefcases, laptops, etc.) must be placed on the x-ray machine belt for screening. All employees, contractors, and visitors must walk through a magnetometer.

Visitors outside of these designated common areas require an escort at ALL times. Visitors must wear their badge above the waist on the front torso, in full view. Visitors must be accounted for at all times and escorted in areas not considered common space.

CMS Cafeteria - Save time and pre order your lunch!

Hours of Operation: 6:30 a.m. - 3:00 p.m., Fridays until 2:00 p.m.

Save time and pre order your lunch! Convenience at your fingertips! Place orders for a personal meal from your desktop, tablet or mobile device. With your personal login you can create, manage and pay for meals from anywhere, anytime. And you can keep track of your orders using a personal event calendar where you can review past orders, repeat favorite orders and make change requests.

CMS CAFETERIA PRE-ORDERS DEADLINE DATE: Wednesday, June 21st by 11:59pm EDT

On-site event attendees can pre-order their lunch in advance in order to expedite the process. **Pre-orders must be done online (see links below) no later than 11:59 pm EDT, Wednesday, June 21st.**

- You must create an account and password in order to place your order for pickup at the CMS cafeteria.
- The account requires that you enter a building and department. Please enter building as "CMS" and department as "Guest" as indicated below.
- **Catering Made Easy**: https://cms.catertrax.com/shopcatgroup.asp?id=1&intOrderID=&intCustomerID
- **Simply to Go Catering**: https://cms.catertrax.com/shopcatgroup.asp?id=2&intOrderID=&intCustomerID

Place orders for a personal meal from your tablet or mobile device. With your personal login you can create, manage and pay for meals from anywhere, anytime. And you can keep track of your orders using a personal event calendar where you can review past orders, repeat favorite orders and make change requests.

Webcast Participants

The webcast will be held Wednesday, June 28th from 12:00 pm - 5:00 pm EDT & Thursday, June 29, 2017 from 9am - 5pm. The Summit can be viewed virtually by using two different application platforms, YouTube or USTREAM. To facilitate easy access to the webcast, please log in 30 minutes early.

Only confirmed registered participants, will be able to access and join the live webcast by clicking the link provided in the registration confirmation.

CMS will provide a call-in feature for this event for use by those attendees who (1) cannot access sound from their computers, or (2) may experience technical difficulties. Attendees should not call the teleconference line unless it is necessary to hear the webcast. Attendees should report technical difficulties by contacting the CTEO TechSupport Team via email at CTEOTechSupport@cms.hhs.gov during the webcast. If you need to utilize the call-in feature, the number will be provided to you at that time.

Enhance your Summit experience by having a viewing party with your colleagues! Please be sure that each person registers for the webcast individually to receive important updates.

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

Understanding the Evolving Marketplace

Day 1 will focus on The Future Role of Assisters

Day 2 will focus on Optimizing Consumer Experience

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

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

Color Code Key of Learning Tracks

= Stabilize the Risk Pool through Outreach and Enrollment

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

= How to Run an Accountability Centered Assister Program

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

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

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

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

TRACK KEY:

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

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2017 CMS Assister Summit

June 29, 2017
9:00AM - 5PM EDT

Theme of Day Two: Optimizing Consumer Experience

Health Insurance Marketplace

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

TRACK KEY:

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

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Learning Track Guide

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

= Stabilize the Risk Pool through Outreach and Enrollment

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

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

= How to Run an Accountability Centered Assister Program

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

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

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

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

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

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Pre-enrollment SEP Verification Process Overview

Over the past months, CMS has taken a number of steps to further its commitment to prevent misuse or abuse of special enrollment periods (SEPs). Specifically, last year, CMS introduced a post-enrollment SEP confirmation process under which consumers enrolling through the most common SEPs on the Federally-facilitated Marketplace were directed to provide documentation to confirm their SEP qualifying event.

Beginning on June 23, 2017, CMS will launch a pre-enrollment SEP Verification (SEPV) process to verify SEP eligibility for consumers newly enrolling in Marketplace coverage through the most common SEP types. Under the process, the Marketplace will create an SEP Verification Issue, referred to as an SVI, for new Marketplace applicants who submit an application and attest to information that qualifies them for an SEP that's subject to pre-enrollment verification. These consumers will be required to submit documents to confirm their SEP eligibility before they can complete enrollment, make their first premium payment, and start using their Marketplace coverage.

Consumers' coverage will start based on their SEP types and dates they choose their plans: for example, a consumer who qualifies for a loss of coverage SEP and chooses a plan on July 25 will have coverage that starts as of August 1, even if she sends documents later in the month and her SEP is verified on August 27. If the saved coverage effective date passes before the SVI is resolved, then the effective date will be retroactive.

Once the Marketplace confirms that the document(s) submitted are sufficient to confirm the consumer's SEP eligibility, the Marketplace will send the enrollment transaction to the issuer and notify the consumer about next steps, such as making his or her first premium payment. Meanwhile, existing Marketplace enrollees who attest to SEP qualifying events will not be subject to pre-enrollment verification.

Implementation Timeline of the Pre-enrolment SEP Verification Process

The Pre-enrollment SEP Verification process will be implemented in two phases. On June 23, 2017 CMS will start Phase 1 of pre-enrollment verification, comprised of the following SEPs:

- Loss of qualifying coverage; and
- Move.

Then, in August 2017, CMS will start Phase 2 of pre-enrollment verification, comprising the following SEPs:

- Marriage;
- Gaining or becoming a dependent through adoption, placement for adoption, placement in foster care, or a child support or other court order; and
- Medicaid/CHIP denial after applying for Medicaid/CHIP during Open Enrollment, or after applying for Marketplace coverage during Open Enrollment or following another SEP qualifying event.

As previously mentioned, consumers with an SVI will be required to submit documents to confirm their SEP qualifying event before they can enroll, make their first premium payment, and start using their

coverage. It's important to note that even for applications in which multiple consumers are affected by the SEP, only one set of documents needs to be submitted.

What happens when an SVI is generated and a consumer must prove his/her SEP eligibility?

- After submitting the application, the consumer gets an eligibility notice telling him/her to send the Marketplace documents that confirm his/her qualifying life event.
- The consumer selects a plan prior to submitting documents to confirm his/her SEP.
- Consumer has 30 days after he/she selects a plan to send documents that confirms his/her SEP eligibility.
- Consumer's plan selection will be pended (on hold) until the Marketplace confirms his/her SEP eligibility. The consumer will receive a pended plan selection notice indicating the 30-day deadline to submit documents to confirm their SEP eligibility. Consumers will not be covered by the health insurance plan they picked at this time.
- Once the Marketplace confirms the consumer's SEP eligibility he/she will receive a resolution notice telling him/her to make his/ her first premium payment. The consumer will be enrolled in coverage with an effective date based on their SEP type and date of plan selection. In some cases, the effective date may be retroactive. Consumer can begin using coverage once they make their first premium payment. If the consumer's coverage is retroactive and the consumer has used health care services after the retroactive effective date of coverage, he/she may be able to submit those claims to be covered by the QHP.

What happens when an SVI is generated and a consumer *does not* prove his/her SEP eligibility?

- If for any reason a consumer does not prove his/her SEP eligibility, the Marketplace will send a notice informing the consumer that he/she will not be enrolled. The notice will also indicate what options the consumer has to seek Marketplace coverage in the future.

What does a consumer need to confirm SEP eligibility?

To prove eligibility for a loss of coverage SEP, a consumer must submit documents that show that he/she or someone else on the consumer's application lost qualifying health coverage in the 60 days before they applied, or will lose coverage in the 60 days after they applied. These documents must include the name of the person who lost coverage and the date of coverage loss.

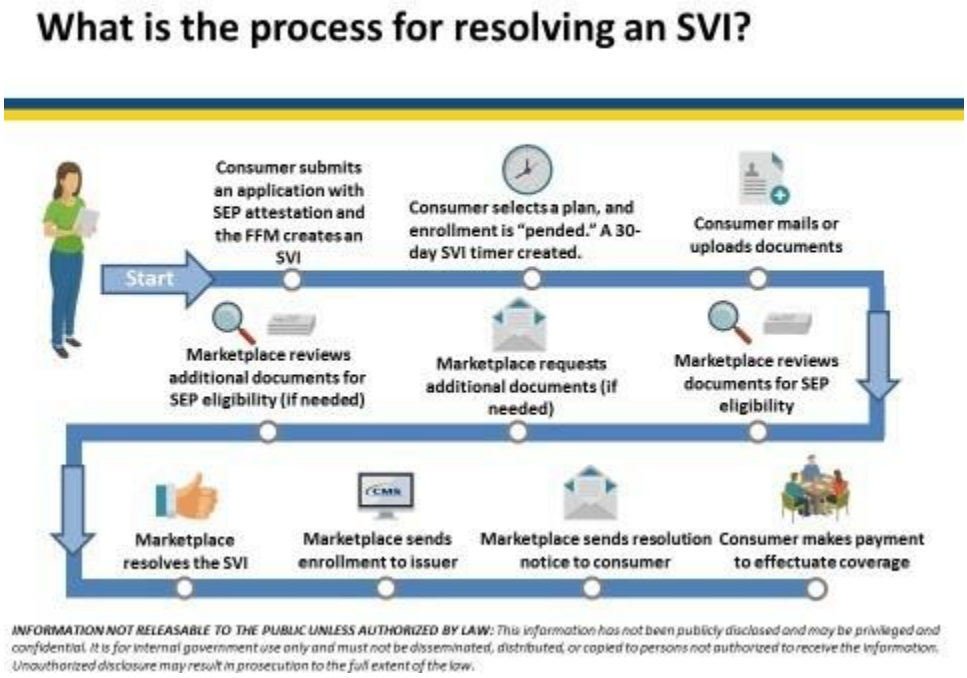
To prove eligibility for the move and prior coverage SEP, a consumer must submit documents that show that he/she or someone else on his/her application moved. These documents must include the name of the person who moved and the date of the move.

- A consumer who moves within the U.S. must submit a document that includes the name of the person who moved, AND shows that this person had qualifying health coverage for at least one day in the last 60 days before their move.
- A consumer who moved to the U.S. from a U.S. territory or from a foreign country does not need to confirm prior coverage, but must submit a document that confirms he/she lived outside of the U.S. prior to their move.

How will the Marketplace get in touch with a consumer who needs to prove SEP eligibility?

A consumer will find information about his/her SVI and documents he/she can submit at the end of their online application and in an eligibility notice he/she can download once he/she has finished the application. When the consumer chooses a plan, he/she will receive a pended plan selection notice with their deadline, 30 days after they chose their plan.

The Marketplace will send the consumer an additional reminder notice as his/her deadline approaches, along with emails reminding him/her to send documents. Note that consumers will be able to view their notices online in their HealthCare.gov account, and that consumers who indicated a preference in their application to receive Marketplace notices by mail will receive these notices by mail.



For more information on which types of documents consumers can submit to resolve an SVI, please refer to the following links:

- How to submit your documents: https://www.healthcare.gov/tips-and-troubleshooting/uploading-documents/
- After you submit documents: https://www.healthcare.gov/verify-information/after-you-submit-documents/
- When the Marketplace asks for more documents: https://www.healthcare.gov/verify-information/
- Special Enrollment Periods Available to Consumers: https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf
- Acceptable Documents (will be live June 23, 2017): HealthCare.gov/help/prove-coverage-loss or HealthCare.gov/help/prove-move

What Assisters Should Know about Consumer Direct Enrollment

How is consumer direct enrollment changing?

On May 17th, CMS announced new streamlined and simplified guidance on the consumer direct enrollment process, as part of a larger CMS effort intended to stabilize the health insurance market by providing more ways for consumers to access coverage. Direct enrollment allows consumers to enroll in Marketplace coverage directly through a web broker or insurance company's website when signing up for individual market coverage through the Federal Marketplace. The new streamlined direct enrollment process is an alternative to consumers signing up for coverage through HealthCare.gov.

In prior years, consumers who signed up for health coverage using a third party website were redirected to HealthCare.gov to complete their application. Consumer feedback showed that the process was confusing and made it harder to finish the application. The new process allows consumers to start and finish their application through the third-party website of direct enrollment partners approved to use the proxy direct enrollment pathway.

During the upcoming open enrollment period, consumers applying for individual market coverage through direct enrollment partners will now be able to complete their application using one website. This offers consumers easier access to healthcare comparisons and shopping experiences for coverage offered through HealthCare.gov.

How do these changes impact the services that Assisters provide to consumers?

Changes to the consumer direct enrollment process impact assisters in terms of the help that assisters provide to consumers that may have enrolled through the direct enrollment pathway.

It's important for assisters to know:

- Assisters should still use healthcare.gov when assisting consumers with enrollment.
- As a result of the expansion of consumer direct enrollment, assisters may see more consumers in need of help that have coverage through the Marketplace but that do not have a HealthCare.gov account.
- Understanding a consumer's enrollment pathway will allow assisters to know which steps are needed to help a consumer in need of guidance.
- A consumer may not know if he or she has a Marketplace application on HealthCare.gov, since he or she might not have used HealthCare.gov to enroll. This makes it important for assisters to ask probing questions about how a consumer enrolled in health coverage.
- If a consumer enrolls using the direct enrollment process, the consumer will not have a HealthCare.gov account. However, the consumer will have an application with the Marketplace.
- All consumers, including those that initially enrolled through direct enrollment, will be required to go through HealthCare.gov to make changes to their application, as well as to resolve data matching inconsistencies (DMIs) and special enrollment period verification (SEP-V) issues.
- If a consumer who enrolled through the direct enrollment process, paper application or the Marketplace Call Center and needs to access his or her application, the consumer should

open a HealthCare.gov account. Once logged into HealthCare.gov, the consumer can use the "Find my existing application" feature to link his or her application to the consumers account by entering his or her application ID. To use the "Find my existing application" feature, the consumer will need the information on the account (name, birthdate, city / state / zip) to match the information on the application in order to successfully associate them. If the consumer needs his or her application ID, the consumer can call the Marketplace Call Center at 1-800-318-2596 (or TTY: 1-855-889-4325).

###

Notices Were Mailed to Consumers Who May Be Enrolled in Marketplace Coverage & Medicare

Key Takeaway: Recently, the Federally-facilitated Marketplace (FFM) mailed paper notices to the household contacts of consumers who may be enrolled in a Marketplace plan and Medicare that qualifies as minimum essential coverage (MEC). The notices include instructions on what to do next. Generally, consumers determined eligible for MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for a Marketplace plan with APTC or income-based CSRs. If consumers who receive this notice contact assisters with questions, assisters can help them understand the notice and complete the necessary next steps.*

*****Medicare Parts A and C are considered MEC. Medicare Parts B and D are not considered MEC.*

Overview

The Federally-facilitated Marketplace (FFM) confirms MEC Medicare enrollment through a Medicare Periodic Data Matching (PDM) process. During this round of Medicare PDM, the Marketplace identified consumers of all ages who are enrolled in MEC Medicare and Marketplace coverage with and without APTC and CSRs (i.e. "dually enrolled" consumers). If the FFM confirms MEC it's possible that these consumers may be at risk for a tax liability if they are receiving APTC for their Marketplace coverage. Therefore, those consumers who are identified as enrolled in MEC Medicare should return to their application to end their Marketplace coverage.

Recently, as part of Medicare PDM, the FFM mailed paper notices to the household contact for all consumers found to be dually enrolled in MEC Medicare and Marketplace coverage with and without APTC. The notices included:

- Names of consumers who were found to be dually enrolled;
- A recommendation that individuals who are found to be enrolled in MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for APTC/CSR through the Marketplace;
- Instructions on the correct action to take on Marketplace coverage (for consumers enrolled in MEC Medicare); and
- Contact information to confirm if they are enrolled in Medicare or if they have any questions.

Q&A: How to help consumers who receive the notice.

Q1: If a consumer is 65, but doesn't have enough quarters to qualify for premium-free Medicare Part A and can't afford premium Part A, do they have to enroll in Part B and can they stay on their Marketplace plan?

A1: For consumers who must pay a premium for Medicare Part A, we recommend that they compare their Marketplace benefits and premiums to Medicare to see what best fits their needs and budget. In this scenario, they would not have to take Part B.

Q2: Shouldn't consumers dually enrolled in MEC Medicare and Marketplace coverage end their Marketplace coverage right away? Won't they have to pay back any APTCs?

A2: Yes, they may be liable to pay back all or some of the APTC paid on their behalf during months of overlapping coverage. We strongly encourage that they end their Marketplace coverage only after they have confirmation of their Medicare Part B enrollment to avoid gaps in coverage.

Q3: What if a person is of Medicare age but does not qualify for premium-free Medicare Parts A or B? Can she still enroll through the Marketplace?

A3: Yes, as long as she is otherwise eligible (e.g. they are lawfully present, their eligibility has been verified through electronic data sources, etc.), she can still enroll in a Marketplace plan.

Q4: Are there special instructions for those who are dually enrolled and entitled to Medicare due to an end-stage renal disease (ESRD) diagnosis?

A4: Consumers with a diagnosis of ESRD can choose between enrolling in Medicare or Marketplace coverage at the time of their ESRD diagnosis. But if a consumer with ESRD does choose to enroll in Medicare Part A, we highly recommend that they enroll in Medicare Part B as well to ensure that all of their medical costs associated with their ESRD diagnosis are covered.

###

Assister Outreach and Education Opportunity to Raise Awareness of Men's Health Care Needs

June is Men's Health Month! Men's Health Month is celebrated nationally with screenings, health fairs, media appearances, and other health equity education and outreach activities. During June, Assisters are invited to take action to help communities achieve their full potential for health through planning outreach and education events with a special focus on men's heath.

The goal of Men's Health Month is to raise awareness across the country of preventable health problems and encourage early detection and treatment of disease among men and boys. Recognition of the importance of men's health care (and preventive care) in June offers health care providers, public policy makers, media, and individuals the opportunity to encourage men and boys to enroll in health care coverage, seek regular medical advice, and early treatment for disease and injury. Thousands of men's health awareness activities occur across the country and around the world in June with many happening during National Men's Health Week (June 12-18, 2017), which falls immediate before and during Father's Day weekend.

Assisters are encouraged to make the most of this special focus on men's health care during June and plan an outreach and education event in your community. Consider collaborating with health care providers or a men's organization in your neighborhood to help get out the word about the

importance of getting covered and utilizing preventative care, as well as seeking treatment for medical needs.

To help jump-start Assister #GetCovered outreach, education, and enrollment efforts around men's health, make use of the Centers for Disease Control and Prevention (CDC) resources on men's health below:

- Advancing Men's Health and Safety: https://www.cdc.gov/men/
- National Men's Health Week: https://www.cdc.gov/men/nmhw/
- Healthy Living Tips for Men: https://www.cdc.gov/men/healthyliving/
- National Center for Health Statistics on Men's Health: https://www.cdc.gov/nchs/fastats/mens-health.htm

###

Summary of "From Coverage to Care" Roadmap Series Steps 4 & 5 Assister Webinar

Throughout the spring and summer we will continue to focus on CMS' Office of Minority Health "From Coverage to Care" initiative, specifically "From Coverage to Care: A Roadmap to Better Care and a Healthier You." The goals of C2C are of course focused on increasing the consumer connection to care and eventually improving health outcomes. Resources online and in print include the Roadmap, Discussion Guides for Community Partners, videos, and more.

We are highlighting the webinars from Wednesday, May 24th and Friday June 9th. We continue to highlight the C2C Roadmap, focusing on Step 4, "Find a Provider" and Step 5, "Making an Appointment."

C2C Step 4: Find a Provider

Step 4 encourages consumers to look for a provider they can trust and work with to improve their health and well-being. Depending on how complicated a consumer's health care needs are, they may need to see more than one type of provider. All consumers will undoubtedly want to find a primary care provider, as we discussed on our most recent webinar. However, many consumers may also have to see a specialist to treat certain services or to treat specific conditions.

Let consumers know that they may need a referral or preauthorization and explain what these terms mean in easy to understand language. After talking to consumers about where to get care, you can begin a discussion about what type of provider to see and how to find one that is right for their needs and takes their coverage. This is also a good time to remind the consumer of the cost implications of finding a provider in out-of-network, and the implications of not getting pre-authorization when their plan requires it.

Key Questions for Consumers

- Were you assigned a provider by your plan or state Medicaid or CHIP program?
- Can you find the list of different provider types in your network – mental health, counselors, podiatrists, allergists?

C2C Step 5: Making an Appointment

After a consumer has identified a provider that is right for him/her, the C2C Roadmap recommends making a doctor's appointment. This is a process that you, as assisters, can help consumers navigate. As you are working with consumers you can highlight the following tips in advance of their call with the provider's office, and coach them on things they should mention or may be asked.

Some helpful tips for Consumers:

Consumers should ask:

- If they can send any forms before arrival
- If they need to bring anything to the visit
- What to do if they need to change or cancel the appointment

Consumers should also:

- Confirm that their provider accepts their coverage.
- Talk to their provider about preventive services.
- Ask questions about their concerns and what they can do to stay healthy.
- Find a health center near you: http://findahealthcenter.hrsa.gov
- Find a mental health provider: http://findtreatment.samhsa.gov
- **Resources Contact C2C** Coveragetocare@cms.hhs.gov

###

Consumer Action Needed - Initial Warning Notices Sent to Consumers Who May Be Enrolled in Marketplace Coverage with APTC/CSRs and Medicaid or CHIP

Key Takeaway: Consumers determined eligible for minimum essential coverage (MEC)[1] *Medicaid or CHIP are not eligible for a Marketplace plan with advance payments of the premium tax credit (APTC) and/or income-based cost-sharing reductions (CSRs). The Marketplace has identified consumers who may be dually-enrolled in a Marketplace plan receiving APTC/CSRs and in MEC Medicaid/CHIP and has sent them notification of their dually-enrolled status. This process is called Medicaid/CHIP Periodic Data Matching (PDM). This summer, the Marketplace will end APTC/CSRs for dually-enrolled consumers who do not take action in response to the Medicaid/CHIP PDM initial warning notice; these consumers will remain enrolled in a Marketplace plan at full cost. Assisters can help affected consumers understand the notice(s) and complete the necessary next steps.*

Overview

- Consumers who are determined eligible for or are enrolled in MEC Medicaid or CHIP are ineligible for APTC and CSRs to help pay for the cost of their Federally-Facilitated Marketplace (Marketplace)[2] plan premium and covered services.[3], [4]

- Medicaid/CHIP PDM is the process the Marketplace uses to identify, notify, and reduce the number of consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers).
- This month, the Marketplace sent an initial warning notice to the household contact for dually-enrolled[5] consumers, stating that if they do not take action by the date in the notice, the Marketplace will end any APTC/CSRs being paid on behalf of affected consumers, and those consumers' Marketplace coverage will continue without financial help. [6]
- The notice tells the household contact (and provides instructions) to do one of the following by a specified date:
    - end affected consumers' Marketplace coverage with APTC/CSRs if they are enrolled in Medicaid or CHIP; or
    - update their Marketplace application to tell the Marketplace that affected consumers are not enrolled in Medicaid/CHIP.

- In Summer 2017, at least 30 days following the initial notice, a **final notice** will be sent to the household contact for applications with affected consumers who did not respond to the initial warning notice by the specified date. This notice will let consumers know that they are still enrolled in a Marketplace plan but will no longer receive financial help.
- For anyone else on the application who is still enrolled in a Marketplace plan, their coverage will continue and eligibility for APTC/CSRs, if applicable, will be redetermined. **Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services should end their Marketplace coverage immediately.** The final notice includes instructions for next steps, such as ending Marketplace coverage, confirming whether or not someone is enrolled in Medicaid/CHIP, and appealing the Marketplace's decision; it also includes the date that the changes to financial assistance become effective. The Marketplace will also send an updated Eligibility Determination Notice (EDN).

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[1] Most Medicaid is considered qualifying health coverage (also known as minimum essential coverage, or MEC). Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) and aren't considered MEC. (For more information on which Medicaid programs are considered MEC, visit HealthCare.gov/medicaid-limited-benefits/). [2] References to the "Marketplace" throughout refer to the Federally-Facilitated Marketplace and State-Based Marketplaces using the federal eligibility and enrollment platform. [3] Generally, a consumer who is eligible for income-based CSRs will also be eligible for APTC. However, not all consumers who are eligible for APTC will be eligible for income-based CSRs. [4] In accordance with recent guidance from the Internal Revenue Service (IRS), if a Marketplace makes a determination or assessment that an individual is ineligible for Medicaid or CHIP and eligible for APTC when the individual enrolls in Marketplace coverage, the individual is treated as not eligible for Medicaid or CHIP for purposes of the premium tax credit while they are enrolled in Marketplace coverage for that year. For more information, visit: https://www.irs.gov/PUP/taxpros/best-_practices_resolving_1095_conflicts.pdf. [5] Due to technical limitations, dually-enrolled consumers in the following Marketplace states will not receive notices in this round of Medicaid/CHIP PDM: Arkansas and Georgia. Consumers in these states will not be affected by this round of Medicaid/CHIP PDM. [6] If a consumer still wants a Marketplace plan after having

been determined eligible for MEC Medicaid or CHIP, he or she will have to pay full price for his or her share of the Marketplace plan premium and covered services, without APTC or income-based CSRs, if otherwise eligible.

How to help consumers who receive the notice(s)

Q1: When and how are these notices being sent to consumers?

A1: The Marketplace sent initial warning notices in June 2017 to the household contact for applications with one or more dually-enrolled consumers. In Summer 2017, the Marketplace will send a final notice to the household contact for applications with consumers who did not take action by the date in the initial warning notice. The Marketplace will also send an updated EDN for all consumers in the household. All notices are mailed to the household contact and/or posted to their Marketplace accounts, depending on what they selected as their communication preference.

Q2: How will consumers identify the Medicaid/CHIP PDM notices, and what do the notices say?

A2: The subject of the initial warning notice reads "*Warning: Members of your household may lose financial help for their Marketplace coverage*." The notice lists the dually-enrolled consumers, and provides instructions to either end their Marketplace coverage with APTC/CSRs, or update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid or CHIP. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, or who aren't sure whether they're enrolled in or have been determined eligible for Medicaid or CHIP.

The subject of the final notice reads "*IMPORTANT: Members of your household are still enrolled in a Marketplace plan but will no longer get financial help.*" The notice lists the dually-enrolled consumers who did not take action by the date in the initial warning notice, tells them the date that Marketplace coverage without financial assistance becomes effective, and alerts the impacted consumers that they should end Marketplace coverage immediately if they don't want to pay full cost for their share of the Marketplace plan premium and covered services. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, OR who aren't sure whether they're enrolled in or eligible for Medicaid or CHIP, as well as information on how to submit an appeal to the Marketplace if a consumer believes his or her financial assistance was ended incorrectly.

Copies of both notices will be available in English and Spanish.

Q3: As an assister, why might consumers contact me, and how can I help them?

A3: Consumers who receive either/both of the Medicaid/CHIP PDM notices may contact assisters: (a) for help understanding the notice(s); (b) for help ending Marketplace coverage with APTC/CSRs; (c) for help updating their Marketplace application to tell the Marketplace they're not enrolled in Medicaid/CHIP; (d) if they don't think they're enrolled in Medicaid or CHIP; (e) if they aren't sure if they've been determined eligible for Medicaid or CHIP, (f) if they aren't sure if they're enrolled in Medicaid or CHIP; or (g) if they want more information about whether their Medicaid or CHIP coverage qualifies as MEC. Here are some examples of the ways that assisters can help consumers who contact them:

- Help consumers understand the notice(s). Explain that the notice has been sent to them because the Marketplace has identified them as being enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP. This is important because consumers who've been

determined eligible for Medicaid or CHIP are not eligible for a Marketplace plan with APTC/CSRs. Consumers who receive the notices should take immediate action.

- Encourage consumers who have been determined eligible for or are enrolled in Medicaid or CHIP to take immediate action to end their Marketplace coverage with APTC/CSRs. Explain the financial impact of not ending Marketplace coverage.
- See these instructions on HealthCare.gov to help a consumer end Marketplace coverage when he or she has Medicaid or CHIP.
- https://www.healthcare.gov/help/end-marketplace-plan/
- Medicaid/CHIP PDM User Interface Guide
    - www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf
- Help consumers who aren't enrolled in Medicaid or CHIP to update their Marketplace application accordingly.
- Medicaid/CHIP PDM User Interface Guide
    - www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf
- **Inform consumers who don't think they're enrolled in Medicaid or CHIP, who aren't sure if their Medicaid or CHIP benefits qualify as MEC, or if they aren't sure if they've been determined eligible for or if they're enrolled in Medicaid or CHIP,** that they should contact their state Medicaid or CHIP agency to confirm their enrollment status (instructions for doing so are in the notices). If the state agency confirms that the consumer is not eligible for or enrolled in MEC Medicaid or CHIP coverage, he or she should update his or her Marketplace application to tell the Marketplace that he or she is not enrolled in Medicaid or CHIP. However, if the state agency confirms that the consumer is eligible for or enrolled in MEC Medicaid or CHIP coverage, the consumer should end his or her Marketplace coverage with APTC/CSRs immediately (refer to the Medicaid/CHIP PDM User Interface Guide, above, for more information).
- **Advise consumers who want more information about Medicaid or CHIP** to contact their state Medicaid or CHIP agency.

Q4: What if a consumer is enrolled in Medicaid or CHIP that counts as qualifying coverage and Marketplace coverage with APTC/CSRs, but believes they are actually eligible to remain enrolled in Marketplace coverage with APTC/CSRs?

A4: A consumer who's enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP that counts as qualifying coverage may believe they are eligible to remain enrolled in Marketplace coverage with APTC/CSRs if they experienced a change in household or income that makes them no longer eligible for Medicaid/CHIP that counts as qualifying coverage. The consumer should contact the state Medicaid/CHIP agency to inform them of these circumstances. If the state Medicaid or CHIP agency informs the consumer that they are no longer eligible for Medicaid or CHIP that counts as qualifying coverage, the consumer should update their Marketplace application to state that they are not enrolled in Medicaid or CHIP that counts as qualifying coverage; they can remain in their Marketplace coverage with APTC/CSRs, if otherwise eligible.

Q5: How soon after the final notice is sent will the Marketplace end APTC/CSRs on behalf of affected consumers?

A5: The Medicaid/CHIP PDM final notice will include the date on which changes to financial assistance will become effective for the household.

For more information, please see this FAQ document for assisters.

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Quality Rating Information Bulletin

Date: June 9, 2017

From: Center for Consumer Information and Insurance Oversight and Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services

Title: Quality Rating Information Bulletin

Subject: Display of 2017 Quality Rating System (QRS) star ratings and Qualified Health Plan (QHP) Enrollee Experience Survey results for QHPs offered through the Health Insurance Exchanges

This Bulletin announces that the Centers for Medicare & Medicaid Services (CMS) will conduct a second year of consumer pilot testing during the 2018 individual market open enrollment period of the display of Qualified Health Plan (QHP) quality rating information[1] by the Federally-facilitated Exchanges (FFEs), including FFEs where the State performs plan management functions, and State-based Exchanges on the Federal Platform (SBE-FPs). CMS intends to use the same criteria for identifying states to participate in the second year of the consumer pilot testing.[2] At this time, we anticipate that the second pilot year will be conducted in the same states that displayed QRS star ratings during the 2017 individual market open enrollment period (i.e., Virginia and Wisconsin).[3] CMS will use this second year of the pilot to conduct testing within the context of a revised open enrollment period established by the Market Stabilization Rule[4], as well as conduct continued testing to inform the public display of QHP quality rating information on Exchange websites. As new policies are implemented to stabilize the Exchanges, CMS remains focused on strategies to improve the value for consumers and reduce burdens for QHP issuers and Exchanges.

In September 2016, CMS published the Quality Rating System (QRS) and QHP Enrollee Survey Technical Guidance for 2017[5] ("2017 Technical Guidance"), which included details about the content, process, and timing of the required display of QHP quality rating information by the Exchanges. This bulletin revises the schedule outlined in the 2017 Technical Guidance with respect to the nationwide display of QHP quality rating information on Exchange websites.[6]

CMS' goals with the second pilot year expand upon the goals from the first consumer pilot test during the 2017 individual market open enrollment period, and include:

• Gathering information regarding the potential impact of the revised open enrollment period of November 1, 2017 to December 15, 2017 on consumer experience with QRS star ratings;

• Obtaining further details about consumer access and use of QHP quality rating information, so as to inform display of QRS star ratings; and

• Informing the development of comprehensive technical assistance and education related to the QRS star ratings for consumers and those assisting consumers with enrollment prior to nationwide public display of quality rating information.

CMS remains committed to providing information about the quality of health insurance coverage offered through the Exchanges. We believe the revised timeframe for nationwide public display of QHP quality rating information will also provide QHP issuers additional time to measure and improve the quality of QHPs offered through the Exchanges using the current QRS measure set and methodology.

The approach described in this bulletin will inform our understanding of the impact of QRS star ratings on consumer behavior in the context of the new guidelines implemented pursuant to the Market Stabilization Rule, and allow CMS to continue to enhance consumer technical assistance using information gathered from an additional year of consumer testing of the display of quality rating information by the FFMs.

The guidance for issuers and SBEs articulated in the April 29, 2016 Bulletin[7] will continue to apply to the second year of consumer pilot testing, with the applicable year references revised to reflect the extension of the consumer pilot test for a second year (e.g., references to the 2017 open enrollment period updated to reflect the 2018 open enrollment period; references to the 2016 QHP quality rating information and 2016 Technical Guidance updated to the 2017 QHP quality rating information and 2017 Technical Guidance).

Please contact the CMS helpdesk with any further questions: CMS_FEPS@cms.hhs.gov.

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[1] The phrase "QHP quality rating information" includes the Quality Rating System (QRS) scores and ratings and the QHP Enrollee Survey results. During the initial years of implementation, Exchanges can satisfy the requirement to display the QHP Enrollee Survey results by displaying the QRS star ratings (which incorporate member experience data from the QHP Enrollee Survey). See, Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule; (May 27, 2014), (79 FR 30240, 30310), available at: https://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf.

[2] See the April 29, 2016, Quality Rating Information Bulletin, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-Bulletin-4292016.pdf.

[3] See the September 27, 2016, UPDATE: Quality Rating Information Bulletin, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/UPDATE-Quality-Rating-Information-Bulletin.pdf

[4] See Patient Protection and Affordable Care Act; Market Stabilization; Final Rule; (April 18, 2017), (82 FR 18346, 18382), available at https://www.gpo.gov/fdsys/pkg/FR-2017-04-18/pdf/2017-07712.pdf

[5] See Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS_and_QHP_Enrollee_Survey_Technical_Guidance.pdf.

[6] In the 2017 Technical Guidance, CMS announced that the quality ratings for QHPs offered through the Exchanges should be displayed in time for the individual market open enrollment period for the 2018 plan year. See ibid.
[7] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-Bulletin-4292016.pdf.

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Updated CMS Bulletin on Network Breadth Information for Qualified Health Plans

Date: June 9, 2017
Title: Network Breadth Pilot
Subject: Updated CMS Bulletin on Network Breadth Information for Qualified Health Plans on HealthCare.gov

Purpose

For plan year (PY) 2018, the Centers for Medicare & Medicaid Services (CMS) intends to continue the network breadth pilot for reporting information on the relative size of provider networks that will display in a limited number of states on HealthCare.gov. Empowering consumers to select the plan that is best for them is a priority for CMS, and the goal of the network breadth pilot is to help CMS understand how consumers make use of network breadth information in their decision-making.

Background

In March 2016, CMS published the HHS Notice of Benefit and Payment Parameters for 2017 final rule[1] which included a new policy to provide additional transparency regarding breadth of provider networks at the county level for consumers choosing a plan on HealthCare.gov. CMS provided additional detail about the methodology used to calculate the network breadth ratings for each plan in the Final 2018 Annual Letter to Issuers in the Federally-facilitated Exchanges (FFE).[2] In the final 2018 Annual Letter to Issuers in the Federally-facilitated Marketplaces, CMS published the anticipated methodology for plan year 2018, which mirrored the 2017 methodology.[3] CMS indicated it plans to continue to test consumer use and experience on Healthcare.gov to enhance and improve the display of QHP network breadth information.

Details of the Pilot

The results of the pilot will determine whether CMS expands the pilot to more States for the 2018 plan year. For PY 2018, network breadth information will continue to display for the selected pilot states: Maine, Ohio, Tennessee, and Texas. During open enrollment, consumers in these pilot states will see information classifying the relative breadth of the plans' provider networks, as compared to other Exchange plans in the county. Consumers will be able to compare networks for three provider types, including adult primary care providers, pediatricians, and hospitals. As described in the 2018 Letter to Issuers, the network breadth ratings will be calculated for each qualified health plan (QHP) issuer in the pilot states using data submitted to CMS as part of its 2018 QHP Application.
In developing the pilot, CMS considered, among other factors, states that provide a sample of plans in geographic areas with a range of network availability. This pilot applies to QHPs on the FFMs in the four selected states. Network breadth information will display to consumers shopping for plans in the individual market only in the pilot states.

CMS will collect data on the 2018 consumer experience from consumers in the four states in which this information will be displayed and use it to inform the display of network breadth information on HealthCare.gov in future years. CMS will consider expanding the network breadth pilot to additional states and/or provider types in future years.

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[1] *HHS Notice of Benefit and Payment Parameters for 2017*, Final Rule, 81 FR 12204 (March 8, 2016).
[2] The Final 2017 letter to Issuers in the Federally-facilitated Marketplaces (February 29, 2016) is available at: https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2017-letter-to-issuers-2-29-16.pdf.
[3] The Final 2018 Annual Letter to Issuers in the Federally-facilitated Marketplaces (FFM) (December 16, 2016) is available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf

###

High Costs, Lack of Affordability Most Common Factors that Lead Consumers to Cancel Health Insurance Coverage

CMS issues two new reports on health insurance enrollment trends

The Centers for Medicare & Medicaid Services (CMS) published two reports, the Effectuated Enrollment report and The Health Insurance Exchanges Trends report. These reports show that after selecting a plan on the Exchanges during open season which ended January 31, 2017, less than two months later nearly 2 million people had not paid their insurance premium to effectuate and maintain their health coverage. This number will be adjusted for individuals who effectuate their coverage in March 2017. Exit survey data also contained in the reports indicate that cost is the top reason cited for ending their coverage. Taken together, these reports provide a better understanding of why consumers are leaving the Exchanges.

"Consumers are sending a clear message that cost and affordability are major factors in their decision to cancel or terminate coverage," said CMS Administrator Seema Verma.

The Effectuated Enrollment Report shows that 12.2 million individuals selected a plan at the end of Open Enrollment, but only 10.3 million followed through to pay the premiums necessary to maintain coverage as of March 15, 2017. This means 1.9 million people had not paid or did not continue paying for the insurance coverage they selected on the Exchange. Additional individuals may effectuate coverage for March of 2017.

The Health Insurance Exchanges Trends Report shows exit survey data from consumers who canceled or terminated their 2017 health plans selected on the Exchange during the open enrollment. Specifically, the report indicates that cost and affordability impact consumer decisions to pay for health coverage.

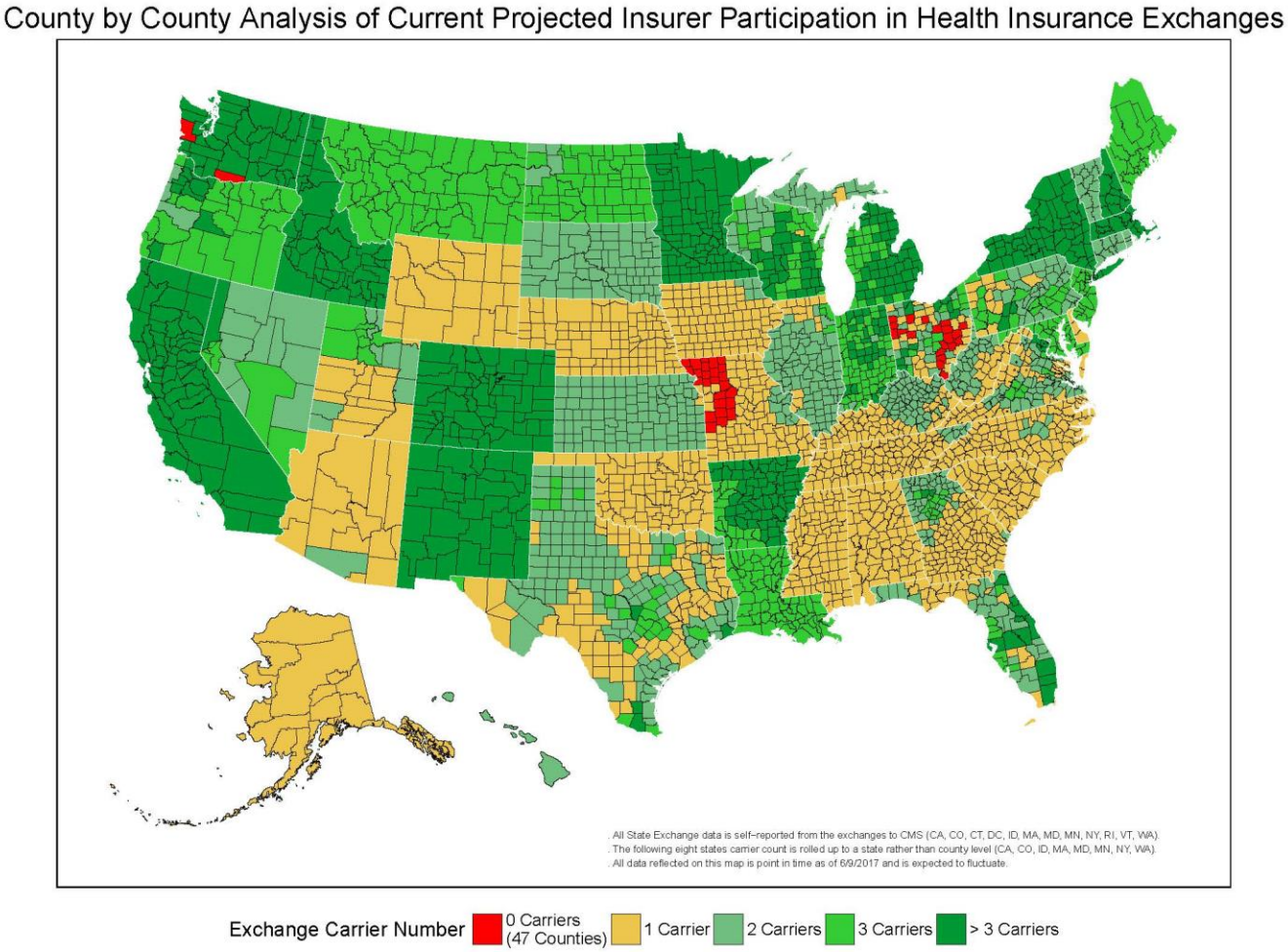
To read the Effectuated Enrollment report, visit: https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

To read the Health Insurance Exchanges Trends report, visit: https://downloads.cms.gov/files/cost-disruptions-trends-report-06-12-17.pdf

###

County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges

The Centers for Medicare & Medicaid Services (CMS) released a county-level map of 2018 projected Health Insurance Exchanges participation based on the known issuer participation public announcements through June 9, 2017. This map shows that insurance options on the Exchanges continue to disappear. Plan options are down from last year and, in some areas, Americans will have no coverage options on the Exchanges, based on the current data.



"This is yet another failing report card for the Exchanges. The American people have fewer insurance choices and in some counties no choice at all. CMS is working with state departments of insurance and issuers to find ways to provide relief and help restore access to healthcare plans, but our actions are by no means a long-term solution to the problems we're seeing with the Insurance Exchanges," said CMS Administrator Seema Verma.

The CMS map displays point in time data and is expected to fluctuate as issuers continue to make announcements on exiting or entering specific states and counties. It currently shows that nationwide 47 counties are projected to have no insurers, meaning that Americans in these counties could be without coverage on the Exchanges for 2018. It's also projected that as many as 1,200 counties - nearly 40% of counties nationwide – could have only one issuer in 2018. Currently, for 2018 at least 35,000 active Exchange participants live in the counties projected to be without coverage in 2018, and roughly 2.4 million Exchange participants are projected to have one issuer.[1] It's expected that the number of consumers with no coverage choices will rise.

CMS continues to work with state departments of insurance and issuers to address bare counties, exploring all options available under current law to provide Americans with access to coverage.

Qualified Health Plan submissions for the Federally-facilitated Exchanges will be accepted by states and CMS through June 21, 2017.

The Department of Health and Human Services (HHS) is committed to doing everything permitted under current law to provide patients with immediate relief from damage the Exchanges has done to the individual and small group health insurance markets. HHS actions are intended to stabilize the markets, increase choices, and lower costs. You can learn more by visiting hhs.gov/relief.

###

CMS Seeks Public Input on Reducing the Regulatory Burdens of the PPACA

The Centers for Medicare & Medicaid Services (CMS) issued a Request for Information (RFI) seeking recommendations and input from the public on how to create a more flexible, streamlined approach to the regulatory structure of the individual and small group markets. Our goal through this process is to identify and eliminate or change regulations that are outdated, unnecessary, or ineffective; impose costs that exceed benefits; or create inconsistencies that otherwise interfere with regulatory reform initiatives and policies.

"We are looking for valuable feedback on how to change existing regulations in ways that put patients first, promote greater consumer choice, enhance affordability and return more control over healthcare to the States," said CMS Administrator Seema Verma. "Through this step, CMS is asking consumers to send us innovative ideas that will help stabilize and strengthen the individual and small group health insurance markets."

Consumers who have obtained coverage through the Exchanges are facing significant premium increases. A recent report issued by our Department of Health and Human Services states that the average premium in the 39 states using HealthCare.gov in 2017 increased from $232 in 2013 to $476 in 2017, which is a 105 percent increase. Consumers are also dealing with fewer plans to choose from and a continuous stream of issuers exiting the Exchanges.

The RFI follows steps CMS has already taken to help improve the health care system, including issuing the Market Stabilization Final Rule on April 18, 2017. This new rule will place downward pressure on premiums, limit special enrollment period abuses, and help to improve choices; while also reducing regulatory burden. The RFI will be open for public comment for 30 days.

To view the Request for Information, please visit: https://www.federalregister.gov/public-inspection/

###

CMS Releases 1991-2014 Health Care Spending by State

Data details health care spending for residents by service and major payer

Today, the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary (OACT) released state-level health care spending data for the period 1991-2014. The data shows that while most states experienced faster growth in 2014 due to Medicaid expansion and enrollment in Exchange plans, per capita health spending in Medicaid expansion and non-expansion states grew at similar rates. The report also found that the most recent economic recession, which ended in 2009, and modest recovery since then, had a sustained impact on health spending and health insurance coverage. Every state experienced slower growth in per capita personal health care spending from 2010-2013 than experienced during the period 2004-2009.

David Lassman, the lead author of the report noted that, "recent economic and health sector factors have had clear impacts by state, both by payer and in the rates of overall per capita personal health care expenditure growth; however, during the 2009 to 2014 period, the variation in spending between the lowest and highest states was virtually unchanged."

The report, published as a web first in Health Affairs, offers vital context for understanding how health spending varies across states. The analysis updates previous estimates published in 2011 and examines personal health care spending (or the health care goods and services consumed) through a resident-based view. These estimates are also presented both by type of goods and services (such as hospital services and retail prescription drugs) and by major payer (including Medicare, Medicaid, and private health insurance) for the individuals who reside in a state.

The topline findings from the report include:

- **Considerable regional variation on personal health care spending:**
  - In 2014, the New England and Mideast regions had the highest levels of total per capita personal health care spending ($10,119 and $9,370, respectively), or 26 and 16 percent higher than the national average ($8,045).
  - In contrast, the Rocky Mountain and Southwest regions had the lowest levels of total personal health care spending per capita in 2014 ($6,814 and $6,978, respectively) with average spending roughly 15 percent lower than the national average.

- **Similar growth in Medicaid expansion and non-expansion states:** While most states experienced faster growth in 2014 compared to 2013 due to Medicaid expansion and enrollment in Health Insurance Exchange plans, per capita health spending in Medicaid expansion and non-expansion states grew at similar rates, 4.4 and 4.5 percent respectively. The similar growth in per capita spending for expansion and non-expansion states was due largely to two effects:
  - Faster growth in the use of healthcare goods and services in expansion states relative to non-expansion states due to a larger increase in the percent of people insured in those states.
  - Faster growth in spending per insured person in non-expansion states relative to expansion states.

- **Impact of recent economic recession and recovery:** The most recent economic recession, which ended in 2009, and modest recovery since then, had a sustained impact on health spending and health insurance coverage.

    - For 2010-2013, per capita personal health spending grew at a rate of 2.8 percent per year on average, substantially slower than during 2004-2009, when spending averaged 5.2 percent growth per year.
    - During 2010-2013, every state experienced slower growth in per capita personal health care spending with an average deceleration of just over two percentage points compared to the 2004-2009 period.

- **Three Major Payers:**

    - **Medicare:** States with above average per enrollee Medicare spending were generally located in the eastern United States while states with the lowest spending were generally in the western United States.
        - The State with the highest per enrollee Medicare spending in 2014 was New Jersey ($12,614) with spending levels roughly 15 percent above the national average ($10,986).
        - In 2014, Montana was the State with the lowest per enrollee Medicare spending, at $8,238 per enrollee (25 percent below the national average per enrollee).

    - **Medicaid:** The recent trends in per enrollee spending were driven by the Medicaid coverage expansion, which increased the share of relatively less expensive enrollees relative to the previous Medicaid beneficiary population mix in expansion states.
        - Total Medicaid spending increased 12.3 percent from 2013 to 2014 for states that expanded Medicaid, compared with 6.2 percent for states that did not expand Medicaid.
        - However, on a per enrollee basis Medicaid spending declined considerably for the expansion states (-5.1 percent) in 2014, because of the enrollment of relatively less expensive enrollees, whereas per enrollee Medicaid spending in the non-expansion states increased 5.1 percent.

    - **Private Health Insurance:** Per enrollee private health insurance spending was $4,551 in 2014, an average annual increase of 3.3 percent since 2009 ($3,872).
        - Total private health insurance spending grew more rapidly in states that did not expand Medicaid eligibility by 2014 than in states that did expand eligibility, at rates of 6.8 percent and 4.6 percent, respectively.
        - A majority of this difference reflects faster private health insurance enrollment growth in non-expansion states (3.2 percent) compared to that for expansion states (1.9 percent).

The OACT data and analysis will appear at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html

An article about the study also being published by Health Affairs here: http://content.healthaffairs.org/lookup/doi/10.1377/hlthaff.2017.0416

###

MACRA/Quality Payment Program (QPP) Updates

Predictive Qualifying APM Participants

The Centers for Medicare & Medicaid Services (CMS) announced predictive Qualifying APM Participant (QP) status for 2017 Advanced APMs. By looking at historical Part B claims data, CMS predicts that nearly 100% of eligible clinicians in Advanced APMs with data currently available will be QPs in performance year 2017.

Click on the links for additional Information:

- Predictive QP Methodology Fact Sheet (PDF)
- Quality Payment Program web site (predictive QP content is located about half-way down the APM page)

###

CMS Is Accepting Future Measures and Activities for Three MIPS Performance Categories

CMS' Annual Call for Measures and Activities for the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program (QPP) is accepting Quality and Advancing Care Information measure proposals through June 30, 2017 for the 2018 program year; measures submitted beginning July 1, 2017 will be considered for the 2019 program year.

CMS encourages clinicians, measure stewards, organizations, and other stakeholders to identify and submit measures and activities to be considered for the Quality, Advancing Care Information, and Improvement Activities performance categories of MIPS in future years.

Submission Details

- **Quality:** Measures proposed for inclusion should be submitted through JIRA. Submissions should include the JIRA Measures under Consideration (MUC) template and other associated documents CMS deems necessary for the submission process.
- **Advancing Care Information:** Measures proposed for inclusion should be sent using the Advancing Care Information Submission Form to CMSCallforMeasuresACI@ketchum.com.
- **Improvement Activities:** Activities proposed for inclusion should be sent using the Improvement Activities Submission Form to CMSCallforActivitiesIA@ketchum.com.

Measures and activities should be relevant, reliable, and valid at the individual clinician level. To be considered, proposals must include measure specifications, related research, and background.

A final list of measures and activities for MIPS clinicians will be published in the Federal Register no later than November 1 of the year prior to the first day of the performance period. Please note that some Advancing Care Information measures finalized in the 2018 final rule may not take effect until 2020, depending on the functionalities and workflow changes needed for implementation.

For More Information
Remember to review the Annual Call for Measures and Activities fact sheet to learn more and

understand the process for submitting measures for the MIPS performance categories. Please direct any questions on measure and activity submissions to the QPP Service Center at QPP@cms.hhs.gov.

###

New Quality Payment Program Resources Available – and New Site Look

The Centers for Medicare & Medicaid Services (CMS) has recently revamped the look of the Quality Payment Program website and also posted new resources to help clinicians successfully participate in the first year of the Quality Payment Program.

CMS encourages clinicians to visit the website to review the following new resources:

- **MIPS Quick Start Guide:** Outlines the steps MIPS clinicians need to take between now and March 2018 to prepare for and participate in MIPS, including checking participation status, choosing to participate as an individual or as part of a group, deciding how to submit data, and selecting measures and activities.
- **Medicare Shared Savings Program and Quality Payment Program Fact Sheet:** Explains how the Shared Savings Program and the Quality Payment Program align reporting requirements for participating Accountable Care Organizations (ACOs) and MIPS clinicians, and how certain tracks in Shared Savings Program ACOs meet Advanced Alternative Payment Model (APM) criteria under the Quality Payment Program.
- **MIPS APM Fact Sheet:** Provides an overview of a specific type of APM, called a "MIPS APM," and the special APM scoring standard used for those in MIPS APMs.

###

Medicare and Medicaid Updates

5 Ways for Healthcare Providers to Get Ready for New Medicare Cards

CMS created a new drop-in article: "5 Ways for Healthcare Providers to Get Ready for New Medicare Cards." The article is designed for you to send out via listservs or newsletters so that you can educate your members about steps for removing Social Security numbers from Medicare cards.

Please let us know when you share this information by emailing partnership@cms.hhs.gov. A Spanish version is available upon request. We appreciate all you do to communicate CMS programs and initiatives.

Thank you,

CMS Office of Communications

Provider Drop-In Article

5 Ways for Healthcare Providers to Get Ready for New Medicare Cards

Medicare is taking steps to remove Social Security numbers from Medicare cards. Through this initiative the Centers for Medicare & Medicaid Services (CMS) will prevent fraud, fight identity theft and protect essential program funding and the private healthcare and financial information of our Medicare beneficiaries.

CMS will issue new Medicare cards with a new unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI) to replace the existing Social Security-based Health Insurance Claim Number (HICN) both on the cards and in various CMS systems we use now. We'll start mailing new cards to people with Medicare benefits in April 2018. All Medicare cards will be replaced by April 2019.

CMS is committed to helping providers by giving them the tools they need. We want to make this process as easy as possible for you, your patients, and your staff. Based on feedback from healthcare providers, practice managers and other stakeholders, CMS is developing capabilities where doctors and other healthcare providers will be able to look up the new MBI through a secure tool at the point of service. To make this change easier for you and your business operations, there is a 21-month transition period where all healthcare providers will be able to use either the MBI or the HICN for billing purposes.

Therefore, even though **your systems will need to be able to accept the new MBI format by April 2018**, you can continue to bill and file healthcare claims using a patient's HICN during the transition period. We encourage you to work with your billing vendor to make sure that your system will be updated to reflect these changes as well.

Beginning in April 2018, Medicare patients will come to your office with new cards in hand. We're committed to giving you information you need to help your office get ready for new Medicare cards and MBIs.

Here are 5 steps you can take today to help your office or healthcare facility get ready:

1. Go to our provider website and sign-up for the weekly MLN Connects® newsletter.
2. Attend our quarterly calls to get more information. We'll let you know when calls are scheduled in the MLN Connects newsletter.
3. Verify all of your Medicare patients' addresses. If the addresses you have on file are different than the Medicare address you get on electronic eligibility transactions, ask your patients to contact Social Security and update their Medicare records.
4. Work with us to help your Medicare patients adjust to their new Medicare card. When available later this fall, you can display helpful information about the new Medicare cards. Hang posters about the change in your offices to help us spread the word.
5. Test your system changes and work with your billing office staff to be sure your office is ready to use the new MBI format.

We'll keep working closely with you to answer your questions and hear your concerns. To learn more, visit: cms.gov/Medicare/SSNRI/Providers/Providers.html

###

CMS Issues Proposed Revision Requirements for LTC Facilities' Arbitration Agreements

The Centers for Medicare & Medicaid Services (CMS) issued proposed revisions to arbitration agreement requirements for long-term care facilities. These proposed revisions would help strengthen transparency in the arbitration process, reduce unnecessary provider burden and support residents' rights to make informed decisions about important aspects of their health care.

Background

The Reform of Requirements for Long-Term Care Facilities Final Rule published on October 4, 2016 listed the requirements facilities need to follow if they choose to ask residents to sign agreements for binding arbitration. The final rule also prohibited pre-dispute agreements for binding arbitration. The American Health Care Association and a group of nursing homes sued for preliminary and permanent injunction to stop CMS from enforcing that requirement. The court granted a preliminary injunction on November 7, 2016. After that decision, CMS reviewed and reconsidered the arbitration requirements in the 2016 Final Rule.

Proposed Revisions to Arbitration Requirements

This proposed rule focuses on the transparency surrounding the arbitration process and includes the following proposals:

- The prohibition on pre-dispute binding arbitration agreements is removed.
- All agreements for binding arbitration must be in plain language.
- If signing the agreement for binding arbitration is a condition of admission into the facility, the language of the agreement must be in plain writing and in the admissions contract.
- The agreement must be explained to the resident and his or her representative in a form and manner they understand, including that it must be in a language they understand.
- The resident must acknowledge that he or she understands the agreement.
- The agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including federal and state surveyors, other federal or state health department employees, or representatives of the State Long-Term Care Ombudsman.

- If a facility resolves a dispute with a resident through arbitration, it must retain a copy of the signed agreement for binding arbitration and the arbitrator's final decision so it can be inspected by CMS or its designee.
- The facility must post a notice regarding its use of binding arbitration in an area that is visible to both residents and visitors.

For more information, the proposed regulation can be found here: https://www.federalregister.gov/public-inspection/

This proposed rule is scheduled to be published in the *Federal Register* on June 8, 2017 and comments are due by August 7, 2017.

###

Medicare Periodic Data Matching Notice

The Exchange has notices to all consumers dually enrolled in an Exchange plan and Medicare. For the first time, the notice will go to all consumers eligible for Medicare regardless of age. Consumers will receive a paper notice asking them to return to the Exchange and follow listed instructions regarding their dual enrollment status to end their Exchange coverage.

For more information the notice and overview can be found under the "Periodic Data Matching Notices" header: https://marketplace.cms.gov/applications-and-forms/notices.html

English(PDF): https://marketplace.cms.gov/applications-and-forms/medicare-pdm-notice-june-2017.pdf
Spanish (PDF): https://marketplace.cms.gov/applications-and-forms/medicare-pdm-notice-spanish-june-2017.pdf

###

Notices Were Mailed to Consumers Who May Be Enrolled in Marketplace Coverage & Medicare

Key Takeaway: Recently, the Federally-facilitated Marketplace (FFM) mailed paper notices to the household contacts of consumers who may be enrolled in a Marketplace plan and Medicare that qualifies as minimum essential coverage (MEC). The notices include instructions on what to do next. Generally, consumers determined eligible for MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for a Marketplace plan with APTC or income-based CSRs. If consumers who receive this notice contact assisters with questions, assisters can help them understand the notice and complete the necessary next steps.*

*****Medicare Parts A and C are considered MEC. Medicare Parts B and D are not considered MEC.*

Overview

The Federally-facilitated Marketplace (FFM) confirms MEC Medicare enrollment through a Medicare Periodic Data Matching (PDM) process. During this round of Medicare PDM, the Marketplace identified consumers of all ages who are enrolled in MEC Medicare and Marketplace coverage with and without APTC and CSRs (i.e. "dually enrolled" consumers). If the FFM confirms MEC it's possible that these consumers may be at risk for a tax liability if they are receiving APTC for their Marketplace

coverage. Therefore, those consumers who are identified as enrolled in MEC Medicare should return to their application to end their Marketplace coverage.

Recently, as part of Medicare PDM, the FFM mailed paper notices to the household contact for all consumers found to be dually enrolled in MEC Medicare and Marketplace coverage with and without APTC. The notices included:

- Names of consumers who were found to be dually enrolled;
- A recommendation that individuals who are found to be enrolled in MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for APTC/CSR through the Marketplace;
- Instructions on the correct action to take on Marketplace coverage (for consumers enrolled in MEC Medicare); and
- Contact information to confirm if they are enrolled in Medicare or if they have any questions.

Q&A: How to help consumers who receive the notice.

Q1: If a consumer is 65, but doesn't have enough quarters to qualify for premium-free Medicare Part A and can't afford premium Part A, do they have to enroll in Part B and can they stay on their Marketplace plan?

A1: For consumers who must pay a premium for Medicare Part A, we recommend that they compare their Marketplace benefits and premiums to Medicare to see what best fits their needs and budget. In this scenario, they would not have to take Part B.

Q2: Shouldn't consumers dually enrolled in MEC Medicare and Marketplace coverage end their Marketplace coverage right away? Won't they have to pay back any APTCs?

A2: Yes, they may be liable to pay back all or some of the APTC paid on their behalf during months of overlapping coverage. We strongly encourage that they end their Marketplace coverage only after they have confirmation of their Medicare Part B enrollment to avoid gaps in coverage.

Q3: What if a person is of Medicare age but does not qualify for premium-free Medicare Parts A or B? Can she still enroll through the Marketplace?

A3: Yes, as long as she is otherwise eligible (e.g. they are lawfully present, their eligibility has been verified through electronic data sources, etc.), she can still enroll in a Marketplace plan.

Q4: Are there special instructions for those who are dually enrolled and entitled to Medicare due to an end-stage renal disease (ESRD) diagnosis?

A4: Consumers with a diagnosis of ESRD can choose between enrolling in Medicare or Marketplace coverage at the time of their ESRD diagnosis. But if a consumer with ESRD does choose to enroll in Medicare Part A, we highly recommend that they enroll in Medicare Part B as well to ensure that all of their medical costs associated with their ESRD diagnosis are covered.

###

Medicare Program; PPS and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology; Extension of Comment Period

Today, the Centers for Medicare & Medicaid Services (CMS) issued a notice extending the comment period for the advance notice of proposed rulemaking (ANPRM) with comment entitled "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology" that appeared in the Federal Register on May 4, 2017 (82 FR 20980) (the ANPRM) on potential revisions to the SNF payment system, based on research conducted under the SNF Payment Models Research project.

The comment period, which would have ended on June 26, 2017, has been extended until August 25, 2017.

For more information on this notice at the *Federal Register* click here (PDF): https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-12324.pdf?utm_campaign=pi%20subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email and 06/14/2017 will be available online at https://federalregister.gov/d/2017-12324

###

SAVE THE DATES - National Training Program Workshops

Registration for the 2017 Centers for Medicare & Medicaid Services (CMS) National Training Program (NTP) workshops will open soon. You will receive more information via email as it becomes available, including directions on how to register. The locations and dates* for the workshops are listed below. You are invited to attend at the location of your choice.

PHILADELPHIA, PA: August 1–2, 2017

KANSAS CITY, MO: August 9-10, 2017*

ARLINGTON, TX: August 8–9, 2017

ST. LOUIS, MO: August 14-15, 2017*

CHICAGO, IL: August 14–15, 2017

LINCOLN, NE: August 24-25, 2017*

DES MOINES, IA: August 29-30, 2017*

SAN FRANCISCO, CA: August 29–30, 2017

PORTSMOUTH, NH: September 6–7, 2017

****Dates subject to change***

What We Will Cover

- High-level and specific information on key aspects of the Medicare program
- A "Current Topics" session to raise awareness of program changes and innovations
- Interactive casework exercises and activities
- Networking opportunities with CMS staff members and other partners who share your commitment
- **NOTE:** Registration requests will be considered on a first-come, first-served basis until each meeting reaches capacity. The number of attendees from the same organization may be limited.
- Please send all questions to: lorelei.schieferdecker@cms.hhs.gov

Upcoming Webinars and Events and Other Updates

Medicare Claims Appeal Process and Statistical Sampling MLN Connects Call

Thursday, June 29, 2017 1:00pm to 3:00pm EST

To register or for more information, visit MLN Connects Event Registration.

Are you aware of recent regulatory changes to the Medicare claims appeal process? During this call, CMS and the Office of Medicare Hearings and Appeals (OMHA) discuss the HHS Medicare Appeals Final Rule, published on January 17, 2017. Learn about changes intended to streamline the administrative appeal processes, reduce the backlog of pending appeals, and increase consistency in decision making across appeal levels. For an overview of the Final Rule, see the HHS fact sheet.

Did you know that certain appeals pending at OMHA may be eligible for more efficient adjudication through statistical sampling? Learn about the expansion of this program based on feedback from the pilot phase and how your participation may advance the adjudication of your appeals.

A question and answer session follows the presentation.

Target Audience: All Medicare Fee-For-Service providers.

###

HHS ASPR/CIP HPH Cyber Notice: On-Going Impacts to HPH Sector from WannaCry

DISCLAIMER: This product is provided "as is" for informational purposes only. The Department of Health and Human Services (HHS) does not provide warranties of any kind regarding any information contained within. HHS does not endorse any commercial product or service referenced in this product or otherwise.

Dear HPH Sector Colleagues,

HHS is aware of two, large, multi-state hospitals systems that are continuing to face significant challenges to operations because of the WannaCry malware. Note: this is not a new WannaCry attack.

The behaviors that have been reported are typical for environments where the WannaCry scanning virus persists, even though the encryption stage has been blocked by anti-virus, or is not executing. The virus can persist even on a machine that has been patched. The virus will not spread to a

patched machine, but the attempt to scan can disrupt Windows operating systems when it executes. The particular effect varies according the version of Windows on the device. For those devices or systems, we are providing additional guidance below.

We are also sharing FDA's emergency phone line for those with questions or reports of malware affecting devices as part of the recommended reporting process below.

You may send additional questions to cip@hhs.gov

Mitigating risks of WannaCry

WannaCry ransomware is a fast-propagating worm which exploits Windows' Server Message Block version 1 (SMBv1) protocol to move through a network or infect other systems on the Internet. However, SMBv1 might not be the only vector of infection for WannaCry, so even patched systems could still be infected if the malware is introduced to the system in a different manner.

Furthermore, a newly patched system could have been previously infected, and if so, would still scan for other vulnerable systems and/or encrypt files. Patching a system is similar to how in physical medicine, a quarantine will prevent an infection from spreading however will not cure the patient who has been quarantined. Reimaging removes the infection in the operating system no matter where the virus is residing.

Mitigate the risk of WannaCry infection by:

- Patch vulnerable systems with the update from Microsoft which fixes the SMBv1 vulnerability: https://technet.microsoft.com/en-us/library/security/ms17-010.aspx
- Disable SMBv1 on all devices, across the network and disable it at the firewall if possible. If it is not possible to disable SMBv1, consider the business-impact for quarantining those devices off the network until another solution can be found.
- See the Tech Support page from Microsoft below for instructions on disabling SMBv1: https://support.microsoft.com/en-us/help/2696547/how-to-enable-and-disable-smbv1-smbv2-and-smbv3-in-windows-and-windows-server
- Block port 445 on all firewalls
- If possible, reimage potentially affected devices to mitigate risk that malware is on the system in the background.
- Use a reputable anti-virus (AV) product whose definitions are up-to-date to scan all devices in your environment in order to determine if any of them have malware on them that has not yet been identified. Many AV products will automatically clean up infections or potential infections when they are identified.
- Work with vendors to make sure both the distribution stage and the encryption stage of WannaCry are detected and blocked.
- Work with vendors or IT support staff to investigate and remediate systems exhibiting network-scanning activity consistent with WannaCry, which could reimaging per the previous bullet point.

If your organization is the victim of a ransomware attack, HHS recommends the following steps:

1. Please contact your FBI Field Office Cyber Task Force (www.fbi.gov/contact-us/field/field-offices) or US Secret Service Electronic Crimes Task Force (www.secretservice.gov/investigation/#field) immediately to report a ransomware event and request assistance. These professionals work with state and local law enforcement and other federal and international partners to pursue cyber criminals globally and to assist victims of cyber-crime.

2. Please report cyber incidents to the US-CERT (www.us-cert.gov/ncas) and FBI's Internet Crime Complaint Center (www.ic3.gov).
3. ****NEW**** If your facility experiences a suspected cyberattack affecting medical devices, you may contact FDA's 24/7 emergency line at 1-866-300-4374. Reports of impact on multiple devices should be aggregated on a system/facility level.
4. For further analysis and healthcare-specific indicator sharing, please also share these indicators with HHS' Healthcare Cybersecurity and Communications Integration Center (HCCIC) at HCCIC_RM@hhs.gov

Additional Resources

- ICS-CERT: vendor-specific security bulletins and FDA, Center for Devices and Radiological documents: https://ics-cert.us-cert.gov/alerts/ICS-ALERT-17-135-01H
- Microsoft Security Bulletin MS17-010 – Critical: https://technet.microsoft.com/en-us/library/security/ms17-010.aspx
- Microsoft Windows Advisory: https://blogs.technet.microsoft.com/msrc/2017/05/12/customer-guidance-for-wannacrypt-attacks/
- Additional Microsoft Information: https://support.microsoft.com/en-us/help/204279/direct-hosting-of-smb-over-tcp-ip
- US-CERT SMB Advisory and Best Practices: https://www.us-cert.gov/ncas/current-activity/2017/01/16/SMB-Security-Best-Practices

###

PRESIDENT'S COUNCIL ON FITNESS, SPORTS & NUTRITION

The President's Council on Fitness, Sports & Nutrition (PCFSN) is pleased to share the following two announcements from our partners in the Office of Minority Health and the Office of Disease Prevention and Health Promotion here at the U.S. Department of Health and Human Services:

New FY 2017 Funding Opportunity Announcement

The Office of Minority Health (OMH) at the U.S. Department of Health and Human Services administers cooperative agreement and grant programs to support projects that implement innovative models to improve minority health and reduce health disparities.

OMH has released a new competitive funding opportunity announcement (FOA) for which applications are now being accepted. Applications are due by August 1, 2017 at 5 PM ET.

Announcement Number: MP-CPI-17-004

Opportunity Title: **Empowered Communities for a Healthier Nation Initiative**

Estimated Funding Level: $5 million per one-year budget period, for a project period of three years

The Office of Minority Health (OMH) at the United States Department of Health and Human Services announces the availability of Fiscal Year 2017 cooperative agreement funds for the Empowered Communities for a Healthier Nation Initiative. The Empowered Communities for a Healthier Nation Initiative seeks to reduce significant health disparities impacting racial and ethnic minorities and/or disadvantaged populations through implementing evidence-based strategies with the greatest potential for impact.

The program is intended to serve residents in communities disproportionately impacted by the opioid epidemic; childhood/adolescent obesity; and serious mental illness.

Learn more about this FOA and how to apply.

Register for the Fourth Physical Activity Guidelines Advisory Committee Meeting

The 2018 Physical Activity Guidelines Advisory Committee will convene its fourth public meeting July 19-21, 2017. Registration is now open. The live videocast will air on: July 19, 2017: 1 - 5pm E.T. July 20, 2017: 8am - 5pm E.T. July 21, 2017: 8am - 11am E.T. Learn the latest on how physical activity affects quality of life; how much physical activity children under age 6 need; if sedentary behavior has an impact on weight status; and more!

Read post

Best regards,

President's Council on Fitness, Sports & Nutrition

###

Now Available: May 24 Assister Webinar, which included topics on From Coverage to Care: Step 4, SEP Verification, and Medicare PDM, can be viewed at: https://goto.webcasts.com/starthere.jsp?ei=1134030&tp_key=8af667b190.

###

Now Available: ONC eMeasurement and Quality Improvement Webinar Recording

On Thursday, May 4, the Office of the National Coordinator for Health Information Technology (ONC) hosted a roundtable on Innovations in the Use of Electronic Health Data for eMeasurement and Quality Improvement. A recording of the event is now available.

More About the Innovations in the Use of Electronic Health Data for eMeasurement and Quality Improvement Roundtable

ONC summarized research on the current state and future opportunities to promote better health and care, improved communication and transparency, rapid translation of knowledge for all stakeholders, and reduction in the burden of data collection and reporting for providers.

Attendees discussed opportunities to foster innovation in electronic data exchange for eMeasurement and quality improvement and national thought leaders shared their experiences and insights about innovative approaches.

The roundtable was supported by Discern Health.

###

Medicare Learning Network Publications & Multimedia

News & Announcements

- MIPS Group Reporting: Registration Period Ends June 30
- MIPS Performance Categories: Accepting Future Measures and Activities until June 30
- Chronic Care Management Services: New Connected Care Materials
- National Men's Health Week 2017
- County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges
- Hospitals and SNFS: Reduce Legionella Risk in Water Systems
- Predictive Qualifying APM Participant Status Announced
- Hospices: Review First Provider Preview Reports by June 30
- IRFs & LTCHs: Review QRP Provider Preview Reports by June 30
- IRF and LTCH Compare Quarterly Refresh
- PEPPER for Short-term Acute Care Hospitals Available
- Quality Payment Program Resources Available
- ONC eMeasurement and Quality Improvement Webinar: Recording Available
- Proposed Revisions to Long-Term Care Facilities' Arbitration Agreements
- World No Tobacco Day

Provider Compliance

- CMS Provider Minute: CT Scans Video
- Duplicate Claims Will Not be Paid

Claims, Pricers & Codes

- 2018 ICD-10-CM Code Files Available
- July 2017 Average Sales Price Files Available

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- IMPACT Act Special Open Door Forum — June 20
- Diagnosis and Treatment of Parkinson's Disease Webinar — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network Publications & Multimedia

- Guidance to Providers that Submit Outpatient Facility Claims and Those That Enter Claims Data via DDE Screens to Reduce Incidence of Claims Not Crossing Over MLN Matters® Article — New
- Quality Payment Program Overview Web-Based Training Course — New
- Scheduled End of the Intravenous Immune Globulin Demonstration MLN Matters® Article — New
- Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians Booklet — Reminder
- Medicare Secondary Payer Booklet — Reminder

###

New Publications

Your Guide to Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program

Medicare's Competitive Bidding Program for Equipment & Supplies - Spanish

Medicare and Home Health Care – Spanish

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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.