

# June Marketplace Update for Assisters

June 2018

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## CDO Refresh Application Guidance, Process Overview & Best Practices

The Centers for Medicaid and Medicare Services (CMS) is currently refreshing the Certified Application Counselor (CAC) Program by implementing an enhanced application and renewal process. The new application process will promote better engagement with our certified application counselor designated organizations (CDOs) and provide the CAC community with an improved user experience. Any organization seeking to provide CAC enrollment assistance to consumers for Plan Year 2019 must apply to become a CDO. Existing CDOs that fail to reapply during the CAC Program re-application window will be de-designated and will not be permitted to certify CACs or assist consumers.

**CMS has sent invitations to reapply to ALL existing CDOs from April through June, requesting organizations re-apply to continue participating in the CAC Program.** Now, we invite all interested organizations, as well as all existing CDOs that

have not yet reapplied, to submit an application to become a CDO for Plan Year 2019. In preparation for the next Open Enrollment Period, the deadline to submit an application to become a CDO is September 14, 2018. CMS will send a follow-up communication in early July to announce that CDO Application is publicly available.

CDO Application technical assistance webinar recordings, user guides, and more can be found [here](#).

**Below please find some CDO Refresh best practices, tips and FAQs:**

**Q1: What are the steps to apply?**

1. Access and complete the CDO Application once it's posted.
2. CMS will review the application and issue a Preliminary Approval email to applicants that meet CAC Program Requirements. The Preliminary Approval includes guidance for the applicants to access and submit the signed CMS-CDO Agreement. **Please note the Preliminary Approval does NOT approve the applicant as a CDO. Applicants are NOT approved as CDOs until the Final Approval email with "CDO Agreement Approved" in the subject line has been sent.**
3. Access and submit the Signed Agreement using guidance from the Preliminary Approval email.
4. CMS will review the CMS-CDO Agreement and issue a Final Approval email to applicants that meet CAC Program Requirements. This Final Approval email, which organizations should keep for their records, will contain the CDO Welcome packet with guidance on next steps for operating as an Approved CDO for Plan Year 2019.

**Q2: I'm an existing CDO but didn't receive an invitation to apply; what should I do?**

As of June 11, 2018, CMS has invited all existing CDO's to reapply to the CAC program. Email invitations were sent from [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov) to all contacts currently on file for each existing CDO organization. Your organization may apply once the CDO Application is publicly posted.

If your organization did not receive an invitation and believe that you are a current CDO in good standing, please (1.) Check your junk/spam folder for your invitation; and, (2.) Check with individuals within your organization to determine if they received the invitation. To ensure you receive communication moving forward, please add [CACQuestions@cms.hhs.gov](mailto:CACQuestions@cms.hhs.gov) to your contacts and spam filters. We also encourage you to update your contact information with CMS by reaching out to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov) and providing: (1.) Organization Name, (2.) CDO ID Number, (3.) Organization Address, (4.) Previous Contacts, and (5.) Name and Email Address of the Current Contacts

**Q3: I've submitted an application or signed agreement but I haven't heard anything; what should I do?**

CMS will immediately confirm receipt of a submission (Application, Agreement, Additional Information, etc.) with a confirmation receipt email. Be sure to check your junk/spam folder for the confirmation receipt as well as check with individuals within your organization to determine if they received the confirmation. If the confirmation receipt cannot be located, then reach out to [CACQuestions@cms.hhs.gov](mailto:CACQuestions@cms.hhs.gov).

CMS will also provide guidance (when applicable) regarding the next steps applicants should take once the submission has been reviewed. Please note that CMS may take up to 30 business days to review and process each submission (i.e. Agreement, Application or Supporting Document), so if you've received a confirmation receipt please know CMS is working to process your submission.

If you have submitted documentation in support of your application and received a confirmation receipt but are still waiting on a Preliminary or Final Approval after 30 business days, send an inquiry to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov).

**Q4: I'm an existing CDO in good standing, can I continue to assist consumers while my CDO application is being processed?**

Yes, applicants that are existing CDOs, in good standing with CMS may continue to assist consumers while their CDO application is being reviewed and processed by CMS. If you're unsure if your organization is an existing CDO in good standing, send an inquiry to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov).

Applicants that are NOT existing CDOs in good standing with CMS are prohibited from assisting consumers while their application is being reviewed and processed. For these applicants, *please note that receiving a Preliminary Approval does NOT mean that your organization is an approved CDO or grant permission to begin assisting consumers. Organizations are prohibited from assisting consumers without a current and valid CDO approval. Your organization is not an approved CDO until you receive final approval in an email with "CDO Agreement Approved" in the subject line.*

**Q5: I've received a Preliminary Approval; what does that mean, what should I do next?**

After an organization submits an application to become a CDO, CMS will issue a Preliminary Approval to applicants that meet CAC Program Requirements. Receiving a Preliminary Approval means the applicant met CAC Program Requirements and is invited to submit the Signed CMS-CDO Agreement for CMS' review and consideration. The Preliminary Approval includes guidance for the organization to access and submit the signed CMS-CDO Agreement, which is the next step in the application process.

*Please note that receiving a Preliminary Approval does NOT mean your organization is approved as a CDO. Your organization is not an approved CDO until you receive final approval in an email with "CDO Agreement Approved" in the subject line.*

**Q6: I've received a Preliminary Approval and never sent in the Signed Agreement; what should I do?**

Organizations that submitted an application and received a Preliminary Approval but did not submit the signed CMS-CDO Agreement should submit the document immediately. CMS will send multiple follow-up requests to the applicant to submit the signed CMS-CDO Agreement and revoke Preliminary Approvals of organizations that fail to proceed on to the Signed Agreement. These applications will ultimately be rejected once the application window has closed.

The Preliminary Approval includes guidance for the organization to access and submit the CMS-CDO Signed Agreement, which is the next step in the application process. If you can't locate your Preliminary Approval email with guidance regarding the signed CMS-CDO Agreement, reach out to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov). *Please note that receiving a Preliminary Approval does NOT mean your organization is approved as a CDO. Your organization is not an approved CDO until you receive final approval in an email with "CDO Agreement Approved" in the subject line.*

**Q7: I've received my welcome packet, does that mean I've completed the reapplication process?**

Yes, once an applicant has submitted both the Application and Agreement, and received approvals for both it is officially a CDO. CMS will send an approval email with "CDO Agreement Approved" in the subject line. This communication will contain a Welcome Packet with important guidance for the next steps for operating as a CDO.

The Welcome Packet contains key information for operating as a CDO for Plan Year 2019 (like your new CDO ID#), so be sure to access the Welcome Packet and follow its guidance as soon as you receive it.

**Q8: I'm having technical issues with the CDO Application, what should I do?**

If you encounter technical issues when accessing the CDO application or agreement, email [CACQuestions@cms.hhs.gov](mailto:CACQuestions@cms.hhs.gov). In your email, provide the steps you took and a screenshot displaying the issue you experienced.

**Q9: What happens if my organization doesn't reapply?**

Any organization that wishes to assist consumers with CACs for Plan Year 2019 must apply to become a CDO. Existing CDOs that fail to reapply during the CAC Program re-application window will be de-designated as CDOs and will not be permitted to certify CACs or assist consumers once the application window has closed.

**Q10: How do I update my contact information with the CAC Program?**

Existing CDO can update their contact information with CMS by reaching out to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov) and providing: (1.) Organization Name, (2.) CDO ID Number, (3.) Organization Address, (4.) Previous Contacts, and (5.) Name and Email Address of the Current Contacts

**Q11: How do I withdraw from the CAC Program?**

If your organization wishes to withdraw from the CAC Program, please do the following:



1. Send your formal written request to CMS at [CACQuestions@cms.hhs.gov](mailto:CACQuestions@cms.hhs.gov). The written request should include your CDO ID and the date when your CMS-CDO agreement should terminate.
2. Your organization should notify its staff and volunteers that, as of the effective date of termination of its agreement with CMS, they will no longer be certified to provide enrollment and application assistance to consumers. You should ensure that neither your organization nor your staff or volunteers hold themselves out to the public as a designated organization or as a CAC, respectively, after the effective date of termination.
3. Please keep in mind that consumer consent documents must be appropriately secured and retained for six (6) years. Your organization's duty to protect and maintain the privacy and security of personally identifiable information (PII) survives its withdrawal from the CAC Program. Please refer to your organization's agreement with CMS, including the appendices to the agreement, for guidance on the requirements for record keeping of PII and personal health information (PHI).
4. You must submit a request to remove your organization's listing(s) from Find Local Help at <https://localhelp.healthcare.gov/update-organization-information/#/>.

**Q12: I have additional questions about the CDO reapplication process, who should I reach out to?**

CDO Application technical assistance webinar recordings, user guides, and more can be found [here](#). If you further questions regarding the CDO Application, please reach out to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov).

**Q13: How can I make sure I get all CAC and Marketplace Assister email updates?**

Update your contact information with the CAC Program by reaching out to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov) and providing: (1.) Organization Name, (2.) CDO ID Number, (3.) Organization Address, (4.) Previous Contacts, and (5.) Name and Email Address of the Current Contacts

Don't forget to update your contact information with the Marketplace Assister Listserv by sending a request to the Assister Listserv inbox ([ASSISTERLISTSERV@cms.hhs.gov](mailto:ASSISTERLISTSERV@cms.hhs.gov)). Write "Add to listserv" in the subject line and please include the email address(es) that you would like to add in the body of your email.

## 2019 Assister Training Update

As we prepare to release the 2019 Assister Certification Training, the 2018 Assister Certification Training that is hosted on the Marketplace Learning Management System (MLMS) was taken offline at 6:00 p.m. (EST) on Monday June 18, 2018. During this "go-dark" period, assisters will not be able to access the certification training. We anticipate that the 2019 Assister Certification Training will be available to CACs in July and to Navigators after the next round of Navigator grants are awarded to align with the grant cycle.

## Assisting LGBTQI Consumers

June is [Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex \(LGBTQI\) Pride Month](#), which presents a great opportunity for assisters to conduct outreach and education efforts with this special population.

Assisters can take the following steps to create targeted outreach and education events for the LGBTQI community.

- **Learn about LGBTQI Health Issues and Concerns:** [Health care access and insurance coverage disparities continue to exist](#) between the LGBTQI community and the general U.S. population.
- **Take Cultural Competency Training:** Out2Enroll offers a [free 90-minute webinar](#) on cultural competency and enrollment questions specific to working with the LGBTQI community. After completion of the webinar, you can sign up to be listed on Out2Enroll's [Assister Locator Tool](#) and self-identify as an LGBTQI-Friendly assister.
- **Know Your Rights and Report Discrimination:** [Section 1557](#) of the Patient Protection and Affordable Care Act (PPACA) prohibits discrimination in health coverage or care on the basis of gender identity or sexual orientation. Transgender individuals are also entitled to [certain rights and benefits](#) through the PPACA. You can inform consumers

about these rights, and connect them to resources to [file a complaint](#) or [get legal advice](#) if they have experienced discrimination.

- **Host LGBTQI-Friendly Enrollment Events:** With OE5 just around the corner, your organization can reach out to LGBTQI populations (to learn best practices for connecting with this population, use this [Pride Toolkit](#) available on Out2Enroll). For further materials, you can order SAMHSA's [free guide](#) to enrollment assistance for LGBTQI communities and incorporate outreach and enrollment strategies from ASPE's [research article](#) when assisting LGBTQI consumers.
- **From Coverage to Care:** Encourage LGBTQI consumers who enroll in coverage to take advantage of free [preventive services](#) and connect to culturally competent care through this [provider directory](#). This helpful [guide](#) is especially useful for connecting LGBTQI folks to coverage and care.

*NOTE: Marketplace.cms.gov includes links to other federal agencies and in some instances, non-government Web sites. We provide these links because they contain additional information that may be useful or interesting and is consistent with the intended purpose of Marketplace.cms.gov. We cannot attest to the accuracy of information provided by these third-party sites or any other linked site. We are providing these links for your reference. Linking to a non-Marketplace.cms.gov Web site does not constitute an endorsement by CMS or any of its employees of the sponsors or the information and products presented on the Web site. Also, please be aware that the privacy protection provided on Marketplace.CMS.gov does not apply to these third-party sites.*

## Assisting Rural Consumers

Approximately 60 million people live in rural areas across the United States. Like many Americans, rural consumers have difficulty understanding their health insurance coverage and navigating the health care system to get the care that they need. Rural communities tend to have unique challenges, such as: limited provider networks; limited access to specialty care; communication barriers exacerbated by limited internet access; and, transportation issues including longer distances to travel for medical care. These barriers make it especially important to ensure information is reaching rural consumers, so that we can best support and empower these consumers to make decisions about their health care. Understanding that rural communities may need different communication and outreach approaches than their urban and suburban counterparts, it's important for assisters to explore varied ways to engage rural populations.

### How Can Assisters Bolster Efforts in Rural Areas?

A lack of visible information about the Marketplace in rural areas may impact consumer knowledge about their health care coverage choices, as well as the turnout at outreach and education events. To maximize consumer engagement, assisters can collaborate with rural communication networks to develop and disseminate easy-to-understand materials and engage consumers in conversations about health care. And, remember that it's important to leverage partnerships. Where possible, reach out to rural focused organizations at the local, state, regional, and national level. Effective collaboration hinges on assessing and utilizing resources in and familiar to the community. Assisters can do the following to bolster education and outreach efforts in rural areas:

- Identify "hub" locations in the community, such as churches, schools, or grocery stores. Going to places consumers go makes it easier and more convenient for these consumers to find out about the Marketplace and their options for health coverage. Outreach efforts should include older individuals under age 65, since they have a higher rate of being uninsured in rural areas than younger individuals.
- Use local media outlets, such as radio stations and newspapers, to advertise education events and showcase enrollment success stories. Harness social media too. Use hashtags to maximize visibility. For example, CMS has recently launched the hashtag: #RuralHealthStrategy.
- Build trust in the community by developing relationships with local institutions, including Community Action Agencies, independent brokers and insurance agencies (subject to applicable CMS guidance on conflicts of interest), and health care providers.
- Help educate local officials and leaders in the community on how they can help promote awareness about the Marketplace and become champions for coverage.
- Create buy-in by ensuring that the community has an understanding of how the whole community benefits when its members have access to health coverage.
- Develop relationships with other resources in rural communities, such as rural hospitals, community health centers, rural extension offices, Office of Rural Health Policy grantees, and USDA rural health offices.

- Develop relationships with other state-level rural health stakeholders, such as State Offices of Rural Health and/or State Health Associations.

#### Resources

- Reference the [Assisting Rural Consumers Webinar Presentation](#) and [Serving Special Populations: Rural Areas Fast Facts for Assisters](#) on Marketplace.CMS.gov
- Visit the [CMS Rural Health Website](#)
  - Check out the [CMS Rural Health Strategy](#)
  - Refer to the [5 Key Objectives Infographic](#) to see what the main focuses of the strategy are
- Review [HRSA's Office of Rural Health Policy Website](#)
- Read HRSA's National Advisory Committee on Rural Health and Human Services [policy brief](#) on the health coverage issues facing rural consumers and recommendations on how to overcome them.
- Find information on the office that deals with rural health in your state on the [National Organization of State Offices of Rural Health Website](#)

## Tips for FFM Assisters on Working with Outside Organizations

Navigators and certified application counselors (CACs) in Federally-facilitated Marketplaces (FFMs) may be required under CMS regulations to provide certain kinds of referrals, or may find it helpful to collaborate or partner with outside organizations as part of outreach and enrollment assistance efforts.

Assisters might find it helpful to work with or refer consumers to:

- **Federal or state programs that offer health care, health coverage, or payment assistance or discounts related to health services**, such as your state Medicaid or Children's Health Insurance Program agency, the VA Health Benefits Program, Medicare and State Health Insurance Assistance Program (SHIP) counselors, Federally Qualified Health Centers, Ryan White HIV/AIDS programs, or AIDS Drug Assistance Programs for lower-cost prescription drugs.
- **Organizations that specialize in disease-specific issues or represent local patient groups** such as the American Cancer Society or the American Diabetes Association.
- **Other local or community organizations** such as homeless shelters; food banks; lesbian, gay, bisexual, and transgender (LGBT) community centers; churches; legal aid organizations; and local colleges and universities.
- **Local businesses** such as coffee shops, malls, farmer's markets, and grocery stores.

Below are some general rules to keep in mind when making referrals, collaborating, or partnering with outside organizations:

1. **Assisters are generally permitted to collaborate with, make referrals to, and recommend the services of specific outside organizations.**
2. To ensure that your referrals, collaborations, and partnerships are fair and impartial, **assisters must apply the same list of objective criteria in selecting each organization you refer consumers to or partner or collaborate with.** Assisters should also consider consumers' best interests and consumers' expressed needs when evaluating outside organizations.
3. **Any assister receiving HHS grant or contract funding must follow the terms of its grant or contract**, as well as all applicable grant or contract regulations, when working with outside organizations.

What you cannot do:

- **Assisters must not accept payment in exchange for providing a referral or recommending the services of an outside organization.**

For more information about working with outside organizations, please see [Tips for FFM Assisters on Working with Outside Organizations \(slide deck\)](#).

## IRS Releases New Percentage Table/Employer-Sponsored Coverage Required Contribution Percentage

In May, the IRS released the [applicable percentage table and employer-sponsored coverage required contribution percentage for tax year 2019](#). Both of these resources are used to determine eligibility for and the appropriate amounts of financial assistance that consumers may qualify for. These resources are also used by the Federal Data Services Hub to calculate eligibility for advance payments of the premium tax credit (APTC) and help consumers and the Marketplace to evaluate whether employees have an offer of affordable Employer-Sponsored coverage (ESC).

The new percentage tables are below:

| Household income percentage of Federal poverty line: | Initial percentage | Final percentage |
|--|--------------------|------------------|
| Less than 133%                                       | 2.08%              | 2.08%            |
| At least 133% but less than 150%                     | 3.11%              | 4.15%            |
| At least 150% but less than 200%                     | 4.15%              | 6.54%            |
| At least 200% but less than 250%                     | 6.54%              | 8.36%            |
| At least 250% but less than 300%                     | 8.36%              | 9.86%            |
| At least 300% but not more than 400%                 | 9.86%              | 9.86%            |

In addition, for plan years beginning in 2019, the required contribution percentage for employee self-only coverage is 9.86 percent of annual household income. Employees whose share of the cost for an employer-based plan covering the employee only (and not his or her dependents) is less than 9.86 percent of their annual household income will not be eligible for APTC or cost-sharing reductions (CSRs) through the Marketplace, assuming the plan meets minimum value standards. If the cost of the employee-only plan exceeds 9.86 percent of consumers' annual household income, or does not meet minimum value standards, they may be eligible for APTC or CSRs through the Marketplace. This is an increase from the 2018 level, which was 9.56 percent. As an assister, it is important for you to review these resources and be familiar with any changes from year to year so that you can educate and help consumers evaluate their options.

## Medicaid/CHIP Data Matching Issues versus Medicaid/CHIP Periodic Data Matching: Identifying and Resolving

Consumers who are eligible for or are enrolled in coverage through Medicaid or CHIP that counts as minimum essential coverage (MEC) are ineligible for advance payments of the premium tax credit (APTC) and for cost-sharing reductions (CSRs) to help pay for their Marketplace plan premium and covered services. The Marketplace checks to see if consumers are eligible for or enrolled in MEC Medicaid or CHIP when consumers apply for coverage and periodically throughout the coverage year.

The Marketplace provides consumers with a **data matching issue** (DMI) notice and notification on their eligibility determination notice (EDN) if our data shows that they are enrolled in Medicaid or CHIP when they apply for Marketplace coverage with APTC/CSRs.

During the coverage year, the Marketplace conducts periodic data matches to identify consumers who may be dually enrolled in both Medicaid or CHIP and a Marketplace plan with APTC or CSRs. The Marketplace will send an initial warning notice for Medicaid/CHIP **periodic data matching** (PDM) to the household contact for the impacted consumers if consumers are found to be dually enrolled.

Both DMI and Medicaid/CHIP PDM notices require consumers to take action. However, the action for a DMI notice is different than the action required for a Medicaid/CHIP PDM notice. A DMI requires the **submission of documents**, whereas a Medicaid/CHIP PDM notice requires that the consumer **update their Marketplace application or end their Marketplace coverage**, as applicable. It's important that consumers understand what the required steps are and take action by the deadlines provided to avoid losing some or all of their financial assistance.

### **Medicaid DMI Notices**

If Marketplace trusted data sources show that a consumer is enrolled in Medicaid or CHIP when they **apply** for Marketplace coverage, the consumer will receive information in their EDN about the DMI, as well as a separate **DMI notice**, with **90 days to respond**. The EDN will be populated in the consumer's account and the consumer will be sent the EDN and DMI notice in the mail. The DMI notice subject line may include: "ACT NOW: You must submit the requested documents immediately or you may risk losing your Marketplace health coverage and/or the help you're getting to pay for your Marketplace health coverage."

During the 90 days, eligible consumers can enroll (or remain enrolled) in Marketplace insurance with APTC/CSRs. If consumers do not submit sufficient documentation to resolve their DMI within 90 days, the Marketplace will end their APTC/CSRs, and they will remain enrolled in coverage through the Marketplace without financial assistance. **Documentation must show that a consumer is not currently enrolled in Medicaid or CHIP** and may include a:

- Letter from health insurer including coverage termination date;
- Statement of health benefits from state Medicaid or CHIP agency; or
- Letter from Medicaid or CHIP

Consumers may submit documents by either uploading them in their Marketplace account on HealthCare.gov or they can send copies in the mail. The fastest way to submit documents is to upload them through consumers' Marketplace account.

The Marketplace will send a notice that indicates nothing further is needed if the documentation is sufficient. If the documentation is not sufficient, the Marketplace will send a notice that indicates additional information is required. If a DMI is unresolved, consumers will receive 90-day, 60-day, and 30-day warning notices as well as a reminder call before their DMIs are set to expire. These notices will be mailed in English or Spanish based on the consumer's language preference.

### **Medicaid/CHIP PDM Notices**

If the Marketplace finds that a consumer is enrolled in Medicaid or CHIP *and* Marketplace coverage with APTC/CSRs when the Marketplace performs Medicaid/CHIP PDM **during the coverage year**, the Marketplace will send an initial warning **notice** to the household contact for the impacted consumer(s); they will have **30 days from the date of the notice to respond**. The subject of the initial warning notice reads "Warning: Members of your household may lose financial help for their Marketplace coverage."

The notice will contain the names of consumers who were found to be dually-enrolled in Medicaid or CHIP and Marketplace Coverage, and links to online instructions for next steps, including how to 1) End Marketplace coverage with APTC/CSRs (for consumers enrolled in or determined eligible for Medicaid or CHIP), and 2) Update their Marketplace application information (for consumers not enrolled in Medicaid or CHIP).

Consumers should respond to the initial warning notice by the date listed on the notice. The action consumers should take depends on their situation:

| If the consumer(s) listed in the notice...                                     | Then they should...*   |
|--|--|
| Agrees with the notice: They are enrolled in Medicaid or CHIP                  | End their Marketplace coverage with APTC/CSRs. Detailed instructions on how to end coverage can be found here: <a href="https://www.healthcare.gov/medicaid-chip/cancelling-marketplace-plan/">https://www.healthcare.gov/medicaid-chip/cancelling-marketplace-plan/</a> . |
| Disagrees with the notice: Knows that they aren't enrolled in Medicaid or CHIP | Update their Marketplace application to tell the Marketplace that the consumer is not enrolled in Medicaid or CHIP.  |

\*Refer to the [Medicaid/CHIP PDM User Interface User Guide](#) for detailed instructions with easy-to-follow screenshots of the application.

Consumers who do not take appropriate action in response to the initial warning notice by the date listed will receive a **final notice**. This final notice will inform consumers who did not respond to the initial warning notice that the Marketplace has ended any APTC/CSRs being paid on behalf of the impacted consumer(s), and that Marketplace coverage for these consumers will continue without financial assistance. The final notice will also inform them that APTC/CSRs will be redetermined, as applicable, for anyone else on the Marketplace plan, and provides the date that these changes become effective for the household.

### **Why is this important?**

Consumers who are determined eligible for or are enrolled in coverage through Medicaid or CHIP that counts as qualifying health coverage (also known as MEC) are ineligible for APTC, and for income-based CSRs to help pay for the cost of their Marketplace plan premium and covered services. Members of their family, however, may still be eligible for APTC/CSRs. Consumers impacted by Medicaid/CHIP PDM for whom the Marketplace ends APTCs/CSRs will be responsible for the full cost of their Marketplace plan premium and covered services as long as they continue to stay enrolled in that coverage.

### **Frequently asked Questions**

#### **Q1: What should assisters do if consumers think they're not enrolled in Medicaid or CHIP, aren't sure if they're enrolled in Medicaid or CHIP, or aren't sure if their Medicaid or CHIP benefits qualify as MEC?**

**A1:** Assister should inform these consumers 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 enrolled in MEC Medicaid or CHIP coverage, the consumer should immediately end his or her Marketplace coverage with APTC/CSRs.
- If the state agency confirms that the consumer is not eligible for or enrolled in MEC Medicaid or CHIP coverage, the consumer should update their Marketplace application to tell the Marketplace that they are not enrolled in Medicaid or CHIP by reporting a life change. The [Medicaid/CHIP PDM User Interface Guide](#) explains what steps should be taken.

### **Resources**

- To learn how the Marketplace conducts Medicaid/CHIP PDM: <https://marketplace.cms.gov/technical-assistance-resources/pdm-identifying-notifying-consumers-in-marketplace.PDF>
- For more information about the steps consumers should take during Medicaid/CHIP PDM: <https://www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf>
- To learn how to cancel a Marketplace plan when you get Medicaid or CHIP, visit: <https://www.healthcare.gov/medicaid-chip/cancelling-marketplace-plan/>
- To learn how to resolve a DMI, visit: <https://marketplace.cms.gov/technical-assistance-resources/helping-consumers-resolve-dmi-.pdf>
- To help determine which documents to send, refer consumers to a list of documents they can use to verify or add information to their application, such as income, citizenship, or immigration status at: <https://www.healthcare.gov/verify-information/>

## **Standing Assister Resources: Helpful Links / Call Center Hours / Contact Us**

### **Links to Helpful Resources**

- Marketplace Assister Training [Resources](#) and [Webinar](#)
- [Technical Assistance Resources](#)
- CMS Marketplace [Applications & Forms](#)

- CMS [Outreach and Education](#) Resources
- [Marketplace.CMS.gov Page](#)
- [CMSzONE Community Online Resource Library Pilot for Marketplace Assisters](#)
- [Find Local Help](#)

### Marketplace Call Center and Shop Center Hours – Closed Independence Day

Health Insurance Marketplace Call Center: 1-800-318-2596 (TTY: 1-855-889-4325). For customer service support, to start or finish an application, compare plans, enroll or ask a question. Available 24 hours a day, 7 days a week. Closed Memorial Day, **July 4th**, and Labor Day. CACs and Navigators should call their dedicated phone lines so the Call Center can better track the needs of assisters. The dedicated Assister Line can also help with password resets and can help with access to non-application SEPs. Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs) for more information on the Assister Line.

- Navigator Marketplace Call Center line: 1-855-868-4678
- CAC Marketplace Call Center line: 1-855-879-2683
- General consumer Call Center line: 1-800-318-2596 (TTY: 1-855-889-4325).

SHOP Call Center: For customer service support, including assisting employers and employees apply for and enroll in SHOP. 1-800-706-7893 (TTY: 711). Available M-F 9:00 am-5:00 pm EST. Closed New Year's Day, Martin Luther King Day, Memorial Day, **July 4th**, Labor Day, Veterans Day, Thanksgiving and the day after, and Christmas.

### Stay in Touch

To sign up for the CMS Assister Newsletter, please send a request to the Assister Listserv inbox ([ASSISTERLISTSERV@cms.hhs.gov](mailto:ASSISTERLISTSERV@cms.hhs.gov)) write "Add to listserv" in the subject line, please include the email address that you would like to add in the body of your email. For requests to be removed from the listserv, please forward a copy of a webinar invite or newsletter received and write "Remove" in the subject line.

If you have specific questions or issues that you would like to see us highlight in our weekly webinar series or here in this newsletter please contact us.

For **HHS Navigator grantees** - please get in touch with your Navigator Project Officer.

For **CAC Designated Organizations in FFM or SPM states** - please send an email to [CACQuestions@cms.hhs.gov](mailto:CACQuestions@cms.hhs.gov).

We welcome questions, suggestions and comments, so please feel free to contact us!

**Please note that the information presented in this Assister Newsletter is informal, technical assistance for assisters and is not intended as official CMS guidance**



Health Insurance Marketplace