

# Findings and Best Practice Recommendations

**January 6, 2016**

**2014 Compliance Reviews and Renewal  
and Discontinuation Notice Reviews for QHP Issuers in FFMs**

# Webinar Agenda

- 2014 Compliance Reviews
- 2014 Renewal and Discontinuation Notice Reviews
- FFM Compliance Evaluation and Enforcement Remedies in 2016
- Looking Ahead to Future FFM Compliance and Notice Reviews
- Additional Best Practices and Recommendations
- Question and Answer (Q&A) Session
- Additional Resources

# 2014 Summary of Findings and Best Practice Recommendations

## ***Compliance Reviews and Renewal and Discontinuation Notice Reviews***

# Compliance Reviews

## Purpose and Scope

- Compliance reviews conducted under 45 C.F.R. 156.715 helped CMS:
  - Assess qualified health plan (QHP) issuer compliance with FFM-specific standards.
  - Learn about common compliance-related issues that may occur in FFMs.
  - Identify ways to improve coordination with states, with respect to oversight activities.
- Compliance reviews focused on FFM certification and operational standards for plan years beginning on January 1, 2014 (2014 Plan Years).
- Compliance reviews tested QHP issuer compliance with FFM-specific standards for 2014 Plan Years outlined in 45 C.F.R. Part 156.
- These reviews are one part of a larger monitoring and oversight framework for QHP issuers operating in the FFMs.

# Coordination With States

- CMS coordinated with states with respect to scheduling the 2014 FFM compliance reviews.
- Additionally, CMS tailored its 2014 compliance reviews to coordinate with reasonably similar state exams or reviews (when these exam/review results were available).

# 2014 Compliance Reviews: Summary of Findings and Recommendations

- CMS selects issuers for compliance reviews based on available performance data and results of ongoing monitoring activities.
- For the 2014 plan year, CMS conducted compliance reviews of 23 unique issuer IDs, 21 of which were selected by CMS and two of which volunteered for the review process, from across 15 FFM states.



# 2014 Compliance Reviews: Summary of Findings and Recommendations

- Compliance reviews included the review of the following 13 functional areas that align with FFM-specific standards.\*
- The following slides summarize the findings and recommendations from the 2014 plan year reviews in these functional areas:

|                                      |                                |
|--------------------------------------|--------------------------------|
| Casework                             | Marketing and Benefit Design   |
| Agent/Broker Oversight               | Network Adequacy               |
| Delegated/Downstream Entities        | Issuer Participation Standards |
| Enrollment Periods                   | Rating Variations              |
| Enrollment Process                   | Termination of Coverage        |
| Health Plan Applications and Notices | Compliance Plans               |
| Record Retention                     |                                |

\*Table entitled “Standards Applicable to Each Functional Area for Compliance Reviews,” which lists the 13 functional areas and corresponding FFM standards can be found in the appendix of the 2014 *Compliance Review Summary Report*, which is available on the CCIIO website.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Casework

- **Requirement:** Issuers are required to investigate and resolve casework through the Health Insurance Casework System (HICS) and:
  - Check HICS daily.
  - Resolve cases within the required timeframes.
- **Findings:** Even though issuers may have been in compliance with the standard, CMS found that a number of issuers had incomplete policies and procedures that:
  - Omitted specific language and processes for checking HICS daily.
  - Omitted the required timeframes for resolving HICS cases.
  - Were still in draft form at the time of review.



# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Casework (continued)

- **Recommendations:**
  - Develop and maintain a formal policy to resolve HICS cases to include:
    - Checking HICS daily.
    - Times for standard/urgent cases.
    - Consumer notice requirements.
  - Check performance data on case resolution times and:
    - Regularly monitor adherence to required timeframes.
    - Regularly assess staffing and training needs.
  - Ensure policies are in place at the beginning of each year.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Agent and Broker Oversight

- **Requirement:** Issuers must verify that affiliated agents/brokers who facilitate enrollment in QHPs offered through FFM:
  - Satisfy applicable FFM registration and training requirements.
  - Maintain licensure and good standing in each state in which the agent/broker operates.
  - Execute the applicable FFM agreements to assist consumers with Marketplace enrollment.
- **Findings:** A number of issuers did not have written policies or procedures to:
  - Verify that affiliated agents/brokers were registered and had completed all training prior to being compensated for assisting consumers with enrollment.
  - Ensure National Producer Number (NPN) and/or names for agents, brokers, or agencies match CMS records.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Agent and Broker Oversight (continued)

- **Recommendations:**
  - Develop and maintain an oversight policy to ensure:
    - Affiliated agents/brokers who are facilitating enrollments through FFM meet FFM requirements prior to compensation.
    - Validate the FFM training and registration records for affiliated agents/brokers who are facilitating enrollments through FFM by verifying the NPN is on the publically available agent/broker completion list.
    - Proactively communicate requirements (and policy changes) to affiliated agents/brokers.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Delegated and Downstream Entities

- **Requirement:**
  - QHP issuers are responsible for ensuring that their respective delegated and downstream entities do not employ marketing practices or benefit designs that discourage enrollment of individuals with significant health needs in QHPs.
  - Issuers executing a delegation agreement must ensure that it specifies the delegated activities and reporting responsibilities, provide for remedies if the delegated entity does not perform satisfactorily, and otherwise conform with the requirements listed in 45 C.F.R. 156.340(b).
- **Findings:**
  - Some issuers had not included required language in vendor contracts executed after October 1, 2013.
  - Some issuers did not have formal policy or procedure for delegation oversight.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Delegated and Downstream Entities (continued)

- **Recommendations:**
  - Ensure all vendor contracts adhere to all applicable standards.
  - Develop and maintain an oversight policy to ensure delegated/downstream entities meet requirements and review and update regularly.
  - Communicate requirements (and policy changes) proactively to all vendors/entities under contract.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Enrollment Periods for Qualified Individuals

- **Requirement:** Issuers must:
  - Enroll qualified individuals during the initial and subsequent annual open enrollment periods.
  - Allow for special enrollment periods (SEP) in cases of specific triggering events.
  - Comply with the rules governing effective dates of coverage, as established by FFMs.
  - Provide accurate communication of effective dates of coverage.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Enrollment Periods for Qualified Individuals (continued)

- **Findings:**
  - Even though issuers may have been in compliance with the standard, some issuers had no formal policy or procedures that:
    - Referenced FFM annual open enrollment periods and/or SEPs, or effective dates of coverage.
  - Some issuers omitted a documented process for completing enrollment in compliance with regulations.
  - Some issuers had incomplete or draft policies or procedures that were not finalized.
- **Recommendations:**
  - Develop and maintain a formal policy to reference annual open enrollment periods, SEP timeframes and requirements, and effective coverage updates.
    - Update and finalize policies, and ensure they contain appropriate management signatures, approval dates, and effective dates.
  - Monitor regulatory updates to ensure policy is compliant with current requirements.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Enrollment Process for Qualified Individuals

- **Requirement:** Issuers must enroll qualified individuals during open enrollment periods and:
  - Enroll a consumer through FFM's only after receiving an eligibility determination from FFM's.
  - Comply with privacy and security standards applicable to safeguarding personally identifiable information (PII).
  - Comply with rules regarding premium payments by individuals, Indian tribes, tribal organizations, and urban Indian organizations as well as premium payment rules regarding privacy and security.
- **Findings:** Even though issuers may have been in compliance with the standard, some issuers did not have formal policies or procedures:
  - That were in effect for the entire plan year, including those related to protecting PII.



# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Enrollment Process for Qualified Individuals (continued)

- **Recommendations:**
  - Develop and maintain a formal policy to define:
    - The enrollment process for FFM products.
    - Reconciliation for advance premium tax credits (APTC)/cost-sharing reduction (CSR) payments.
    - Payment of premiums by third-party payers.
  - Monitor regulatory updates to ensure policy is compliant with current requirements.
  - Implement policies and processes that protect the privacy and security of consumer PII/protected health information (PHI).
    - Report any security breach, regardless of the number of consumers affected to CMS.
      - Breaches must be reported within 24 to 72 hours of the incident.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Health Plan Applications and Notices

- **Requirement:** Issuers must ensure the accessibility of health plan applications and notices, including:
  - Making these documents accessible for individuals in accordance with the Americans with Disabilities Act (ADA) and for individuals with limited English proficiency.
- **Findings:** Some issuers were inconsistent in the inclusion of language taglines in their consumer notices for:
  - Individuals with disabilities and/or limited English proficiency.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Health Plan Applications and Notices (continued)

- **Recommendations:**
  - Review consumer notices and create or revise standard notice templates to adhere to CMS-issued guidance, and include language taglines that:
    - Explain how individuals with disabilities can access services.
    - Provide individuals with limited English proficiency information on accessing language services.
  - Monitor regulations and guidance for updates and ensure they are incorporated into notice templates.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Record Retention

- **Requirement:** Issuers must comply with the FFM standards for 10 years of records maintenance.
- **Findings:** Even though issuers may have been in compliance with the standard, some issuers had incomplete policies that:
  - Did not reference the 10-year requirement.
- **Recommendations:**
  - Revise/update record retention policy for FFM records to reflect the 10-year requirement.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Marketing and Benefit Design

- **Requirement:**
  - Issuers must not employ marketing practices or benefit designs that discourage enrollment of individuals with significant health needs in QHPs.
  - Issuers must ensure that all individuals belonging to protected classes are not discriminated against in regard to enrolling in QHPs.
- **Findings:** Even though issuers may have been in compliance with the standard, some issuers had incomplete policies that:
  - Excluded language on how employees should self-report non-compliance.
  - Were newly written and not in effect for the entire plan year.
- **Recommendations:** Review and revise policies and procedures to:
  - Include all protected classes and individuals with significant health needs in non-discrimination policies.
  - Develop a process for staff to self-report non-compliance.
  - Educate staff and delegated entities on these policies and procedures.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Network Adequacy Standards

- **Requirement:** Issuers must maintain a sufficient provider network by:
  - Ensuring services are accessible to all enrollees without unreasonable delay, consistent with network adequacy provisions of section 2702(c) of the Public Health Service (PHS) Act.
  - Maintaining a network sufficient in number and types of providers, including access to essential community providers (ECPs), mental health, and substance abuse services.
  - Publishing a provider directory online and in hard copy upon request. The directory should also identify providers that are not accepting new patients.
- **Findings:** Even though issuers may have been in compliance with the standard, some issuers had newly written or incomplete policies and procedures that:
  - Omit FFM-specific language or reference to Marketplace products.
  - Include provider directories that:
    - Omit date of most recent update.
    - Omit information on whether providers are accepting new patients.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Network Adequacy Standards (continued)

- **Recommendations:**
  - Update provider directories regularly.
  - Include FFM-specific language in policies.
  - Include the date of the most recent directory update, and:
    - Include information on whether providers accept new patients.
    - Ensure hard copies (printed from the online version) include all required information.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Rating Variations

- **Requirement:** Issuers must charge the same premium rate without regard to whether a plan is offered through a FFM, directly from the issuer, or through an affiliated agent or broker.
- **Findings:** Even though issuers may have been in compliance with the standard, some issuers had policies and procedures that were:
  - Newly written and not in effect for the entire plan year.
  - Outside of established processes or had no policies in place for ensuring the same rate among similar products on or off FFMs.
- **Recommendations:**
  - Develop and maintain a formal policy and process to ensure the same rates for similar plans on and off FFMs.
  - Conduct testing when rates are set each year to validate parity of rates among similar plans on or off FFMs.



# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Termination of Coverage for Qualified Individuals

- **Requirement:** Issuers must:
  - Terminate coverage only under certain permitted circumstances.
  - Provide termination of coverage notices promptly to affected enrollees.
  - Establish a policy for handling terminations of coverage due to nonpayment of premiums.
  - Follow the special termination guidelines for recipients of APTC.
  - Provide payment delinquency notices to affected enrollees.
  - Maintain termination of coverage records in accordance with FFM-specific standards.
  - Comply with the rules for effective dates of termination of coverage.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Termination of Coverage for Qualified Individuals (continued)

- **Findings:** Even though issuers may have been in compliance with the standard, some issuers had incomplete policies that:
  - Omitted language describing termination initiated by the enrollee.
  - Did not include all circumstances by which an enrollee could be terminated.
  - Omitted record retention requirements for terminated enrollees.
  - Were newly written and not in effect the entire plan year.
- **Recommendations:**
  - Define all circumstances for termination of coverage.
  - Include the process for handling termination of coverage when initiated by the enrollee.
  - Include record retention consistent with FFM standards of 10 years.
  - Ensure policies are reviewed annually and are effective the entire plan year.

# 2014 Compliance Reviews: Summary of Findings and Recommendations

## Compliance Plans

CMS also reviewed each issuer's compliance plan (if available), which was not a formal requirement for plan year 2014, but illustrates issuers' commitment to compliance with FFM-related requirements.

- **Observations:** Reviewed compliance plans were:
  - Newly written, incomplete, or not in effect the entire plan year.
  - Missing FFM-specific language.
- **Recommendations:**
  - Review and update compliance plans annually.
  - Include FFM-specific language.
  - Include processes to protect consumer privacy and security.
  - Include in compliance plan: appropriate management signatures, approval dates, and effective dates.

# 2014 Renewal and Discontinuation Notice Reviews - Purpose and Scope

- CMS reviewed QHP renewal of coverage notices and QHP discontinuation of a product notices.
- More than 1,000 notices were reviewed, representing 42 issuers selected through sampling.
  - Review excluded stand-alone dental plans (SADPs) and multi-state plans.

# 2014 Renewal and Discontinuation Notice Reviews - Purpose and Scope

## Content of Notice Reviews included:

- General format and content of the notices.
- Whether notices were sent in a timely manner.
- Accuracy of notice recipient.
- Whether issuers effectively communicated deductible, maximum out-of-pocket (MOOP) costs, and cost-sharing changes for eight benefit types, and whether the changes matched CMS records.
- Eight benefits were reviewed: in-patient, emergency services, primary care, specialist visits, generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs.

# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Notice Format and Content

- **Requirement:**

- Issuers renewing coverage or discontinuing a product must provide written notice in a form and manner specified by CMS.
- Except in states that develop and require issuers to use a different form that is at least as consumer protective as the Federal standard notices, issuers in the individual market were provided the option of using either the June 26, 2014, or September 2, 2014, bulletin to fulfill this requirement.
- Under 45 C.F.R. 156.1255, issuers renewing coverage of a QHP product in the individual market must include certain information in their applicable renewal notices, including information about premiums and APTC. Per the September 2, 2014 bulletin, issuers must provide contact information for the consumer to call with questions and, in describing significant changes to the consumer's plan, specify whether the metal level of the consumer's plan changed.

# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Notice Format and Content (continued)

- **Findings:** Most issuer notices:
  - Used the correct template as provided by CMS guidance.
  - Included premium and APTC amounts.Some issuer notices:
  - Omitted metal change information from notices.
  - Communicated changes that did not match CMS records.
- **Recommendations:**
  - Review the recommended attachment types per CMS guidance for each change in QHP status and ensure notices are aligned correctly to limit consumer confusion.
  - Develop policies and procedures for creating notices in alignment with CMS guidance.
  - Conduct quality batch testing on notices at the QHP and Variant ID level to ensure pertinent information required by the template is correctly populating.
  - Include the consumer's correct plan name, metal level (and change from prior metal level, if applicable), premium, and APTC in the notice.

# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Timeliness

- **Requirement:** Per the June 26, 2014, and September 2, 2014, bulletins, issuers must provide written notices to consumers in a timely manner.
  - For renewal notices, this means before the first day of the open enrollment period.
  - For discontinuation notices, this means at least 90 calendar days before the date the coverage will be discontinued.
    - HHS stated that it would not take enforcement action against issuers that sent discontinuation notices on the same timeframe as renewal notices, and encouraged states to provide similar flexibility.
- **Findings:** Nearly all notices reviewed were sent to consumers prior to open enrollment.
  - A small number of notices were sent after open enrollment.
- **Recommendations:**
  - Ensure policies and procedures incorporated these notice timelines.



# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Notice Recipient

- **Requirement:** The regulations related to renewal and discontinuation notices require that issuers send written notices to all plan enrollees.
- **Findings:** Approximately 99 percent of notices that were sent to consumers matched CMS records.
  - A few issuers sent notices to names that did not match CMS records (e.g., different last name, different full name, or truncated letters in last name).
- **Recommendations:**
  - Conduct quality assurance against enrollee records to ensure the correct names are listed in notices prior to sending them to consumers.

# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Deductible and MOOP

- **Requirement:** Per the June 26, 2014, and September 2, 2014, bulletins, issuers must also include in the notice or supporting documents:
  - Significant changes to coverage, including but not limited to:
    - Changes in deductibles.
    - Cost-sharing.
    - Metal level changes.
    - Covered benefits.
    - Eligibility.
    - Provider network.
- **Findings:** Of the notices reviewed:
  - More than half communicated a change in deductible or MOOP that matched CMS records.
  - A very small percentage communicated a change that did not match CMS records.
  - The remaining notices either did not communicate the change to the consumer or directed the consumer to a generic website to locate changes to his or her plan.

# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Deductible and MOOP (continued)

- **Recommendations:**
  - Cross-check a sample of notices from each QHP offered against deductible and MOOP amounts for consumers, including consumers from different geographic areas.
  - List clearly in notices or in a Summary of Benefits and Coverage (SBC) any changes to deductible or MOOP.
  - Ensure a website link directs the consumer to the location of his/her plan, if providing a link for additional information beyond those changes listed in the notice/SBC.

# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Benefit Cost-Sharing

- About one in 10 of all the notices reviewed were selected for an in-depth evaluation to determine if cost-sharing changes for eight benefit categories matched CMS records including:
  - In-patient services, emergency services, primary care, specialist visits, generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs.

# 2014 Renewal and Discontinuation Notice Reviews: Summary of Findings and Recommendations

## Benefit Cost-Sharing (continued)

- **Findings:** Cost-sharing structure changes and cost-sharing amount changes were examined. Issuers that did not communicate either of these changes often directed consumers to a generic website. These generic website links did not provide information directly applicable to QHPs, but rather required consumers to locate their QHPs on the site and then find the relevant changes.

### **Recommendations:**

- Cross-check a sample of notices from each QHP offered against cost-sharing amounts and structure for consumers, including consumers from different geographic areas.
- List clearly in an SBC any changes to benefit cost-sharing structure or amounts.
- Ensure a website link directs the consumer to the location of his/her plan, if providing a link for additional information beyond those changes listed in the notice/SBC.

# FFM Compliance Enforcement Remedies in 2016

- **Suppression** (45 C.F.R. 156.815)
  - Temporarily making a certified QHP unavailable for new enrollments on HealthCare.gov.
  - Change in circumstance enrollments have to be done through the Marketplace Call Center. Issuers are expected to do outreach to existing enrollees if a plan is suppressed.
- **Civil Money Penalties** (45 C.F.R. 156.805)
  - Fines can be as high as \$100 per day per individual adversely affected.
- **Decertification** (45 C.F.R. 156.810)
  - Removal of QHP from FFM.
  - Enrollees receive SEPs and will not retain APTC/CSR if they remain enrolled.

# Looking Ahead to Future FFM Compliance and Notice Reviews

- Good faith compliance policy (45 C.F.R. 156.800(c)) expires December 31, 2015.
- Issuers can expect greater use of Marketplace enforcement remedies for non-compliance.
- Enforcement remedies will be assessed based on the severity and scope of the non-compliance.
- FFM compliance reviews may be conducted as standard reviews, expedited reviews, or targeted reviews. QHP issuer selection will be based on multiple factors including:
  - Analysis of certification data.
  - Performance data.
  - Specific issues of non-compliance.
  - CMS account managers (AMs) or state partners may also nominate QHP issuers for compliance reviews.

# Additional Best Practices and Recommendations

- Issuers are encouraged to document their policies and procedures on their FFM activities including documentation on the implementation of an effective compliance plan.
  - 45 C.F.R. 156.705 requires issuers to maintain documentation around FFM activities for 10 years.
- QHP issuers should ensure written policies and procedures contain the following:
  - Origination date and approval date.
  - Approver(s) and approver title(s).
  - Date of implementation/effective date.
- Policies should be reviewed at least annually.



# Additional Best Practices and Recommendations

- Review your existing policies and processes as they relate to FFM operations and update them (including an explicit reference to FFMs as may be appropriate).
- Contact your account managers if you have questions.
- Implement a mechanism for self-monitoring of compliance; update your compliance plan on a regular basis.
- Work diligently to address potential compliance issues once they are identified.

# Questions?

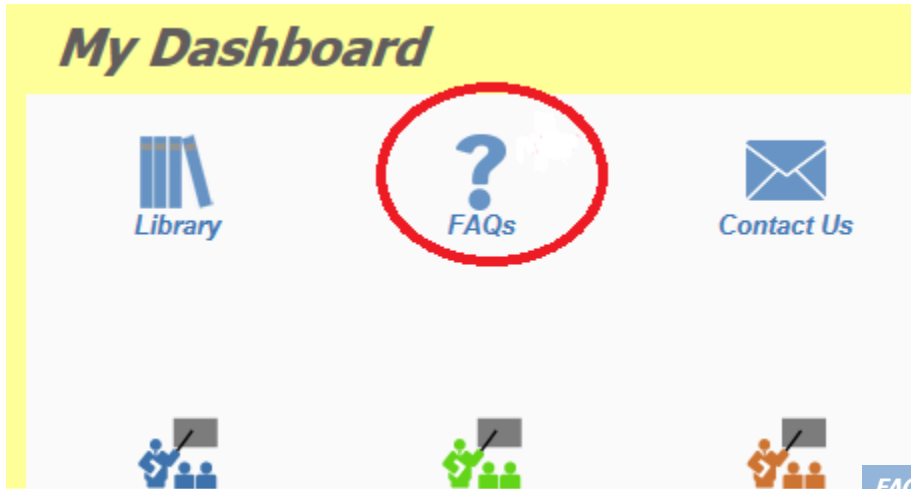
- To submit questions by webinar:
  - *Type your question in the text box under the “Q&A” tab*



# Resources

- Regulation
  - 45 C.F.R. Part 156 – *Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges*
- Guidance
  - Key Priorities for FFM Compliance Reviews for the 2014 Benefit Year ([https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance\\_Review\\_Table\\_032814\\_508.pdf](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table_032814_508.pdf))
  - Key Priorities for FFM Compliance Reviews for the 2015 Benefit Year ([https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance\\_Review\\_Table\\_032715\\_508.pdf](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Compliance_Review_Table_032715_508.pdf))
  - 2016 Letter to Issuers on Federally-facilitated and State Partnership Exchanges (February 20, 2015) (<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>)

# FAQ Database on REGTAP



The Frequently Asked Questions (FAQ) Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary categories, and Publish Date

The FAQ Database is available at <https://www.REGTAP.info/>

FAQ Search

FAQ ID  Enter numeric FAQ ID only

Keyword/Phrase

Program Area

Select All  
Agent Broker  
Distributed Data Collection for RI and RA/Edge Server  
Enrollment and Eligibility  
Event Registration and Logistics

Primary Category

Secondary Category

Publish Date

Start Date  22 End Date  22

# Agent/Broker Webinar Session Survey

- CMS welcomes your feedback regarding this webinar series and values any suggestions that will allow us to enhance this experience for you.
- Shortly after this call, we will send a link to you for a convenient way to submit any ideas or suggestions you wish to provide that you believe would be valuable during these sessions.
- Please take time to complete the survey and provide CMS with any feedback.



# Closing Remarks