CMS Region 7 Updates – 07/28/2017

Table of Contents

ACA/Marketplace Updates

2018 Health Insurance Exchanges Issuer County Map

The Centers for Medicare and Medicaid Services today posted an update to the Health Insurance Exchanges Issuer County Map. This map is of projected issuer participation on the Health Insurance Exchanges in 2018 based on the known issuer public announcements through July 26, 2017. Participation is expected to fluctuate and does not represent actual Exchange application submissions.

Recent data shows that between 2016 and 2017, the average premium increase for all Qualified Health Plans (QHPs) offered on the Health Insurance Exchange in the individual market was 21.6 percent. Also, carrier participation in the Health Insurance Exchange has seen a 31.2 percent decrease since its peak participation in 2015.

This map currently shows that nationwide 40 counties are projected to have no issuers, meaning that Americans in these counties could be without coverage on the Exchanges in 2018. It's also projected that 1,332 counties - over 40 percent of counties nationwide – could have only one issuer in 2018. This could represent more than 2.3 million Exchange participants that will only have one choice and may not be able to receive the coverage they need. Currently for 2018, at least 27,660 Americans currently enrolled for health coverage on the Exchanges live in the counties projected to be without coverage in 2018.

###

CMS Released Guidance Regarding Annual Eligibility Redetermination and Reenrollment

This guidance outlines the policies that the Federally-facilitated Exchange will operationalize for the upcoming Open Enrollment period. These policies and procedures ensure that an enrollee may take no action and maintain coverage across benefit years and this guidance serves as a model for State-based Exchanges to follow, if desired.

###

The Marketplace Learning Management System (MLMS) Is Closed for Plan Year 2017

Plan year 2017 Marketplace registration and training for agents and brokers closed on the MLMS on July 21, 2017. CMS will be launching plan year 2018 registration in early August. For more information, check out the Agents and Brokers Resources webpage or register for one of the upcoming plan year 2018 registration and training webinars listed in the Upcoming Events and Trainings section below.

###

MACRA/Quality Payment Program (QPP) Updates

Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Proposed rule & Request for Information provide flexibility, support strong patient-doctor relationships

On July 13, CMS issued a proposed rule that would update Medicare payment and policies for doctors and other clinicians who treat Medicare patients in CY 2018. The proposed rule is one of several Medicare payment rules for CY 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

The Physician Fee Schedule is updated annually to include changes to payment policies, payment rates, and quality provisions for services furnished to Medicare beneficiaries. This proposed rule would provide greater potential for payment system modernization and seeks public comment on reducing administrative burdens for providing patient care, including visits, care management, and telehealth services. The rule takes steps to better align incentives and provide clinicians with a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program. The rule encourages fairer competition between hospitals and physician practices by promoting greater payment alignment, and it would improve the payment for office-based behavioral health services that are often the therapy and counseling services used to treat opioid addiction and other substance use disorders. In addition, the proposed rule makes additional proposals to implement the Center for Medicare and Medicaid Innovation's Medicare Diabetes Prevention Program expanded model starting in 2018.

For More Information:

- Proposed Rule

###

Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes

Proposed rule and Request for Information promote improvements to quality, accessibility, and affordability of care

On July 13, CMS issued a proposed rule that updates payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule is one of several for 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility and innovation in the delivery of care.

The OPPS and ASC payment system are updated annually to include changes to payment policies, payment rates, and quality provisions for those Medicare patients who receive care at hospital outpatient departments or receive care at surgical centers. Among the provisions in this rule, CMS is proposing to change the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B program. The proposed rule also includes a provision that would alleviate some of the burdens rural hospitals experience in recruiting physicians by placing a two-year moratorium on the direct supervision requirement currently in place at rural hospitals and critical access hospitals. In

addition, CMS is releasing within the proposed rule a Request for Information to welcome continued feedback on flexibilities and efficiencies in the Medicare program.

For More Information:

- Proposed Rule
- Fact Sheet

See the full text of this excerpted Press Release (issued July 13).

###

CMMI Behavioral Health Summit Announcement (CMS-5525-N)

CMS is announcing a meeting to discuss ideas for potential behavioral health payment and care delivery models. The all-day meeting will be held at CMS headquarters on September 8, 2017.

The Summit will provide valuable public discussion and ideas for the Innovation Center to explore potential payment model and care delivery options in the future. The CMS Innovation Center Behavioral Health Summit aims to bring together community health organizations, medical societies, patient advocacy groups, government and non-government agencies, and other interested parties to discuss ideas for a behavioral health model to improve access, quality, and cost of care for beneficiaries with behavioral health conditions by sharing experiences in behavioral health payment and care delivery related to the following topics:

- Substance use disorders
- Mental health and medical comorbidities
- Alzheimer's disease and related dementias
- Behavioral health workforce challenges

DATES: Meeting Date: This meeting will be held at 10 a.m. until 5 p.m. Eastern Standard Time (EST) on Friday, September 8, 2017. The meeting is open to the public, but attendance is limited to the space available.

Meeting Registration: Individuals must register on-line at https://innovation.cms.gov/resources/behavioral-health-paymentcare-summit.html by 12:00 a.m. EST on August 25, 2017.

###

Explanation of Special Status Calculation

The Centers for Medicare and Medicaid Services (CMS) has introduced new information on qpp.cms.gov that indicates whether clinicians have "special status" and can therefore be considered exempt from the Quality Payment Program.

To determine if a clinicians' participation should be considered as special status under the Quality Payment Program, CMS retrieves and analyzes Medicare Part B claims data. A series of calculations are run to indicate a circumstance of the clinician's practice for which special rules under the Quality Payment Program will affect the number of total measures, activities or entire categories that an

individual clinician or group must report. These circumstances are applicable for clinicians in: Health Professional Shortage Area (HPSA), Rural, Non-patient facing, Hospital Based, and Small Practices.

For more information, please visit the Quality Payment Program website.

###

Now Available: Accredited Online Course – Quality Payment Program 2017 Merit-Based Incentive Payment System: Improvement Activities Performance Category

A new, online and self-paced overview course on the Quality Payment is now available through the MLN Learning Management System. Learners will receive information on:

- The Improvement Activities performance category requirements, and how this category fits into the larger Quality Payment Program
- The steps you need to take to report Improvement Activities data to CMS
- The basics about scoring of the Improvement Activities performance category

This course is the third course in an evolving curriculum on the Quality Payment Program, where learners will gain knowledge and insight on the program all while earning valuable continuing education credit. Keep checking back with us for updates on new courses. First time learners will need to register for the MLN Learning Management System. Once registered, learners will be able to access additional courses without having to register. For information on how to login or find training, please visit our MLN Learning Management System FAQ sheet.

The Centers for Medicare & Medicaid Services designates this enduring material for a maximum of 0.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Credit for this course expires June 1, 2020. AMA PRA Category 1 Credit™ is a trademark of the American Medical Association.

###

Accreditation Statements

Please click here for accreditation statements.

###

UPDATED LINK: NOW OPEN: Submissions API Developer Preview

If you're a Developer working on Quality Payment Program reporting, there are new APIs and Github Repositories available to help you: http://qpp.cms.gov/developers

Ready to Get Started?

You can email the Quality Payment Program Service Center at QPP@cms.hhs.gov to get your API Token. (Not a Developer. Please forward along to your team!)

###

IRF Quality Reporting Program: Non-Compliance Letters

CMS provided notifications to facilities that were determined to be non-compliant with Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) requirements for CY 2016, which will affect their FY 2018 annual payment update (APU). Notifications were sent from CMS via the Medicare Administrative Contractors (MACs) and non-compliance notifications were placed into facilities' Quality Improvement and Evaluation Systems (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 18, 2017. Facilities that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 17, 2017. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the IRF Quality Reporting Reconsideration and Exception & Extension webpage.

###

LTCH Quality Reporting Program: Non-Compliance Letters

CMS provided notifications to providers that were determined to be non-compliant with Long-Term Care Hospitals (LTCH) Quality Reporting Program (QRP) requirements for CY 2016, which will affect their FY 2018 annual payment update (APU). Notifications were sent from CMS via the Medicare Administrative Contractors (MACs) and non-compliance notifications were placed into providers Quality Improvement and Evaluation Systems (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 18, 2017. Providers that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 17, 2017. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the LTCH Quality Reporting Reconsideration and Exception & Extension webpage.

###

IRF, LTCH, and SNF Quality Reporting Program Data due August 15

Quality Reporting Program (QRP) data for Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Skilled Nursing Facilities (SNFs) is due August 15 for the first quarter of 2017:

- IRF-PAI, LTCH CARE Data Set, and SNF Minimum Data Set assessment data
- IRF and LTCH data submitted to CMS via the Center for Disease Control and Prevention's National Healthcare Safety Network for discharges

Run validation/output reports prior to each quarterly reporting deadline to ensure you submitted all required data. For a list of measures required for this submission deadline, visit the QRP websites:

- IRF Quality Reporting Data Submission Deadlines
- LTCH Quality Reporting Data Submission Deadlines
- SNF QRP Measures and Technical Information

###

LTCH Quality Reporting Program Refresher Training Webinar — August 22

Tuesday, August 22 from 2 to 4:00 pm ET

CMS is hosting a webinar for Long-Term Care Hospitals (LTCH) providers. Visit the LTCH Quality Reporting Training webpage for more information and to register.

###

SNF Quality Reporting Program: Non-Compliance Letters

CMS provided notifications to facilities that were determined to be non-compliant with Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) requirements for Quarter 4 of CY 2016, which will affect their FY 2018 annual payment update (APU). Notifications of non-compliance were placed into facilities' Quality Improvement and Evaluation Systems (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 14, 2017 and also mailed directly to providers. Providers that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 13, 2017. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the SNF Quality Reporting Reconsideration and Exception & Extension webpage.

###

Applications for the New Health Information Technology Advisory Committee Now Open

Want to contribute to future heath IT policies and standards? You may now apply to become a member of the new Health Information Technology Advisory Committee (HITAC). Applications for the Department of Health and Human Services appointments on the committee will be accepted until noon (EST) on August 4, 2017. We encourage interested professionals to fill out a Health IT Advisory Committee Membership Application to be considered as a committee or future task force member.

The 21st Century Cures Act requires the Secretary of Health and Human Services to appoint three members; one shall be a representative of HHS and one shall be a public health official. The remaining members will be appointed by the Comptroller General of the United States and the majority and minority leaders of the Senate, and the speaker and minority leader of the House of Representatives.

To learn more, read the Federal Register notice that was put on display July 24, 2017

###

2018 Assister Training Update

As we prepare to release the 2018 Assister Certification Training, the 2017 Assister Certification Training that is hosted on the Marketplace Learning Management System (MLMS) will be taken offline at 12:01 P.M. on Friday July 21, 2017. During this "go-dark" period, assisters will not be able to access the certification training. We anticipate that the 2018 Assister Certification Training, which will contain

program updates and improved learning format, will be available to assisters in early August. Assisters who need to take the training before the 2018 training is available should begin the 2017 Assister Certification training prior to July 14, 2017 to allow for enough time to complete the training before it is removed July 21st.

###

2017 CMS Assister Summit Videos and Session Materials

Thank you to all of the assisters who participated in the 2017 Assister Summit. We hope that you had an enriching experience. Videos and session materials from the summit are available here: https://www.cms.gov/Outreach-and-Education/Training/CTEO/Event_Archives.html

###

Important New Rules for Consumers who Fail to Pay Their Premiums: Changes to Guaranteed Availability

*Key Takeaway: Under the recently finalized Marketplace Stabilization Rule, as of June 23, 2017, a health plan issuer may apply any payments a consumer makes for new coverage (a binder payment) with that issuer**[1]** towards past-due premiums**[2]** owed to that issuer. The issuer may also refuse to effectuate the new coverage if the consumer**[3]** fails to pay past-due premiums owed from the 12-month period preceding the effective date of new coverage.*

It is very important for assisters to help consumers understand the consequences of non-payment of premiums. Previously, issuers were prohibited from applying a binder payment to past-due premiums and issuers were required to effectuate the consumer's new enrollment under the guaranteed availability rules. As of June 23rd issuers may apply the binder payment to an individual's past debt to that issuer, from the 12 months preceding the effective date of new coverage, before applying the payment toward a new enrollment. The individual, however, must be provided notice of the issuer's binder payment policy before the binder payment can be applied to the past debt.

For example, Claire was covered with Issuer A and stopped making payments in July 2017. Claire was receiving Advanced Payments of Premium Tax Credit (APTCs), so after her three month grace period, Issuer A terminated Claire's coverage in October. In November, Claire would like to come back to the Marketplace during open enrollment to seek 2018 coverage. Claire enrolls with Issuer A and makes her binder payment. Under these new rules, Issuer A can apply Claire's 2018 binder payment towards her debt owed to Issuer A and choose not to effectuate her 2018 coverage, unless Claire pays all her past-due premiums. Claire must pay the outstanding premium debt before the end of open enrollment for 2018, in addition to the 2018 binder payment, in order to enroll with Issuer A for 2018 coverage.

Here are some important tips for assisters:

1. Let consumers know that if they wish to terminate their coverage, they should do so proactively rather than simply fail to pay their premiums. By actively terminating their coverage, consumers will not be liable for premiums of months that they did not pay and did not have coverage. Failing to pay will impact the consumer's ability to sign up for new coverage in the future with the same issuer. Tell consumers: "If you want to terminate, choose a date!"

2. Help consumers review their enrollment materials and notices from the issuer. Issuers who choose to implement this policy must describe in any enrollment application materials, and in any notice regarding non-payment of premiums, the consequences of non-payment on future enrollment.
3. An issuer may only condition the effectuation of new coverage on payment of past-due premiums for the individual contractually responsible for the past-due premium.
4. If a consumer pays past due premiums, let him or her know that the issuer is required to pay all appropriate claims for services rendered to the consumer during any months of coverage for which past due premiums are collected.

[1] This includes any issuer in the issuer's controlled group. A controlled group means a group of two or more corporations that are treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended, or a narrower group as may be provided by applicable State law.

[2] "Past-due premiums'' refers to premiums that have not been paid by the applicable due date as established by the issuer in accordance with applicable Federal and State law. It does not include premiums for months in which individuals were not enrolled in coverage.

[3] Only the individual who is contractually obligated to make the payment would have his or her new coverage effectuation conditioned on past-due premiums. Dependents under the prior 12-month period of coverage could purchase new coverage for themselves from the issuer (or issuer's controlled group), without paying past-due premiums.

###

Coverage Gap SEP vs. Medicaid/CHIP Denial SEP: Understanding the Difference

Assisters and consumers sometimes experience confusion about the difference between:

The special enrollment period (SEP) for consumers who were previously in the "Coverage Gap"; and

The SEP for consumers who have been denied Medicaid or CHIP eligibility after applying for Marketplace coverage during Open Enrollment or after another SEP qualifying event.

Assisters can refer to the chart below to understand the differences between these two SEPs in terms of eligibility and the application process.

	"Coverage Gap SEP"	Medicaid/CHIP Denial SEP
What is this SEP?	Available to consumers who recently become newly eligible for help paying for Marketplace coverage because their household income increased, their family size changed, or they moved to a different state and they were previously both of these: 1. Ineligible for Medicaid coverage because the consumer lived in a state that hasn't expanded Medicaid. 2. Ineligible for help paying for coverage because the consumer's household income was below 100% of the Federal Poverty Level (FPL). Remember: An increase in income alone will not automatically make a consumer eligible for APTC; there might be other reasons why a consumer may not be eligible for APTC, such as having access to other coverage that counts as qualifying coverage (also known as minimum essential coverage, or MEC).	Available to consumers who applied for Medicaid or Children's Health Insurance Program (CHIP) coverage during the Marketplace Open Enrollment Period, or after a qualifying event, and their state Medicaid or CHIP agency determined they (or anyone in their household) weren't eligible. Remember: Consumers cannot qualify for an SEP to enroll in Marketplace coverage due to a Medicaid/CHIP denial if they applied directly with their state Medicaid agency outside of OE, even if they experienced an event that may have been an SEP qualifying event
Who is Eligible?	– Consumer resides in a non-Medicaid expansion state or resided in one during the last 60 days – Was previously ineligible for APTC solely because of a household income below 100% of the Federal Poverty Level (FPL), AND – Was ineligible for Medicaid during that same timeframe because their state didn't expand Medicaid – Has experienced a subsequent change in household income or family size or a move to a new state that makes him or her newly eligible for APTC	Please see above
Are there any pre-qualifications?	**No**, the consumer does not need to have applied previously and does not need a denial letter.	**Yes**. To access this SEP, the consumer **must** have applied for coverage during an OEP at either the state or the Marketplace, or applied for coverage through the Marketplace after another SEP qualifying event.

		Beginning in August 2017, eligibility for this SEP will need to be verified before the Marketplace finalizes consumers' enrollment through this SEP. Some consumers will be verified electronically based on FFM records, but others will need to submit proof of the denial to confirm their SEP.
How long does the consumer have to apply for the SEP?	The consumer has up to 60 days from the date that he or she experienced the change in household income or family size or move that made him or her newly eligible for APTC to call the Marketplace to report this change.	The consumer has up to 60 days after being determined ineligible for Medicaid or CHIP to apply and select a plan.
Where can the consumer go to gain access to the SEP?	• Call the Marketplace Call Center The Coverage Gap SEP is not available through the Marketplace application. Consumers may call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to describe their situation. *Important tip: Assisters can help a consumer update their Marketplace application online to reflect their change in household income before calling the Call Center. Consumers must be found eligible for APTC on their new application in order to qualify for this SEP.	• Go to his or her Online Application or call the Marketplace Call Center Marketplace Application: Consumers who initially applied for coverage during Open Enrollment can submit a Marketplace application. Marketplace Call Center: Consumers who initially applied for Marketplace coverage after another SEP qualifying event can call the Marketplace Call Center.
What's the process to request this SEP?	Here are the recommended steps to access this SEP, if eligible: 1) Complete a Marketplace application online at HealthCare.gov or by calling the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to determine if the consumer is eligible for APTC. 2) Call the Marketplace Call Center or let the Call Center Representative know that the consumer was previously ineligible for Medicaid because he or she lives or lived in a non-Medicaid expansion state, and was previously ineligible for APTC because his or her household income was too low, but the consumer has now experienced an increase in household	Generally, a consumer can request this SEP through his or her Marketplace Application. Nonetheless, a consumer may need to call the call center if he or she originally applied for coverage outside Open Enrollment, or if he or she wants to request retroactive coverage.

	income, change in household size, or a move that makes him or her newly eligible for APTC. 3) Once the Call Center Representative confirms that the consumer is newly eligible for APTC, the Representative will forward the consumer's application to the Marketplace to determine eligibility for this SEP. Reviews should be completed within 15 calendar days or 10 business days, barring exceptional circumstances. The consumer should expect a letter within a few days after that. 4) If the consumer is eligible for this SEP, the letter will instruct the consumer to return to his or her Marketplace application or call the Marketplace Call Center to complete the enrollment process. If the consumer is not eligible for this SEP, the consumer must wait until the next Open Enrollment Period or they qualify for a different SEP to enroll in coverage.	
What's the coverage effective date for this SEP?	Regular ("15th of the month") coverage effective dates. Coverage is effective the first day of the following month if a plan is selected between the 1st and the 15th of the month. It's effective the first day of the next following month if a plan is selected between the 16th and the last day of the month.	Accelerated prospective or retroactive coverage effective dates. If the consumer receives the SEP through the application, the coverage effective date will be prospective with accelerated effective dates, so the coverage will start on the first day of the month following plan selection. Consumers can contact the Marketplace Call Center they would like their coverage to be effective retroactive to the date they would have had coverage if they had originally been determined eligible for Marketplace coverage.

Medicaid Gap SEP FAQs

Q: I live in Georgia, a state that did not expand Medicaid. During open enrollment, I helped a consumer who had income below 100% FPL. She didn't apply for Marketplace coverage during the annual open enrollment period and doesn't have a Marketplace account. Now, her income has gone above 100% FPL and she is newly eligible for APTC. Is she eligible for this SEP even though she didn't apply for Marketplace coverage during the annual open enrollment period?

A: Yes - a consumer in this situation may be eligible to enroll in Marketplace coverage under the Coverage Gap SEP, because she meets the requirements described above. Consumers aren't required to have previously applied for Marketplace coverage during the OEP in order to qualify.

Reminder: The Marketplace sometimes needs more information to verify consumers' income, regardless of when they apply and enroll in coverage. In these cases, the Marketplace requests additional documentation to resolve what is known as a data matching issue (DMI).

Q: I'm an Assister in Texas, and I'd like to provide enrollment assistance to consumers at job fairs whose income will likely rise above 100% FPL in the near future, making them newly eligible for APTC. How soon after the qualifying increase in income will I be able to help the consumer apply for Marketplace coverage under this SEP?

A: The consumer has 60 days from the date that he or she experienced the change in household income, or household size, or move to a new state that made him or her newly eligible for APTC to come to the Marketplace to report this change and enroll in coverage.

Q: I'm still unsure about how to help my consumer apply for this SEP? I don't see the relevant questions on the application.

A: The consumer must call the Marketplace Call Center to request this SEP; however the SEP is not granted immediately. After the consumer attests to the information above, the call center representative will forward the consumer's request for this SEP to the Marketplace for review. The consumer will be notified by mail of their eligibility for this SEP. The letter will inform the consumer of the next steps he or she should take to enroll in coverage, if the consumer is found eligible.

Q: I am working with a consumer who was eligible for APTC during open enrollment but chose not to enroll. They are ineligible for Medicaid and would now like to enroll in Marketplace coverage. Does this consumer qualify for this SEP?

A: No. A consumer in this situation would not qualify for this SEP. Consumers must have previously had an income below 100% of the FPL that made them ineligible for APTC through the Marketplace.

Additional Resources:

Medicaid Coverage GAP SEP Presentation - https://marketplace.cms.gov/technical-assistance-resources/medicaid-coverage-gap-sep.pdf

Medicaid Denial SEP Guide-

https://marketplace.cms.gov/outreach-and-education/applying-for-coverage.pdf

###

Special Enrollment Period Pre-enrollment Verification Process: Resolving a Verification Issue

The May 24th and June 9th, 2017 assister webinars provided an in depth review of the new Special Enrollment Period Pre-enrollment Verification (SEPV) process to verify Special Enrollment Period (SEP) eligibility for consumers newly enrolling in Marketplace coverage through certain SEPs. As discussed during these presentations, beginning on June 23, 2017, consumers newly enrolling in Marketplace coverage through an SEP due to a move or due to a loss of qualifying coverage (also called minimum essential coverage), will be required to submit documents to confirm their SEP eligibility before they can begin using their coverage.

- **Click here to view the slides from these presentations.**

Consumers who qualify for these SEPs will be asked to submit documents that prove their SEP eligibility in the **Eligibility Determination Notice (EDN)** that they receive after submitting their application. Assisters can download a model of the EDN that consumers will receive, which includes a list of documents they can submit. To do so, please click here, scroll down to "Eligibility Notice" and use the link below, "Special Enrollment Period Pre-Enrollment Verification (June 2017)."

Consumers' deadline to submit documents is **30 days after they pick a plan.** Once they confirm their plan selection, consumers will receive a **pended plan selection notice** with this deadline. Like the EDN, this notice will also include a list of documents consumers can submit. Consumers' plan selections will be pended (put on hold) until the Marketplace confirms their SEP eligibility based on the documents they send. Consumers won't be able to use their coverage during this time, and should contact the Marketplace if they have questions. Consumers who don't send documents by their deadline could be found ineligible for this SEP and lose their opportunity to enroll in Marketplace coverage until the next annual open enrollment period, unless they experience another SEP qualifying event.

Submitting Documents

To confirm a loss of qualifying coverage, consumers must submit documents that show that someone on their 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. **Click here** to see a list of acceptable documents.

To confirm a move and prior coverage, consumers must submit documents that show that someone on their application moved. These documents must include the name of the person who moved and the date of the move. **Click here** to see a list of acceptable documents.

- **Consumers who moved from 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.
- **Consumers who moved to the U.S. from a U.S. territory or a foreign country** do not need to confirm prior coverage, but they must submit a document that confirms they lived outside of the U.S. prior to their move.

As a last resort, consumers who don't have acceptable documents can submit a letter explaining:

- Loss of coverage: the coverage they had, why and when they lost it or will lose it, and the reason they can't provide documents.
- Move: the date of their move, their old and new addresses, and the reason they can't submit documents.

To submit this type of documentation, consumers can select "Letter of explanation" when uploading documents online or mail the letter to the Marketplace. **Consumers should try to submit one or more acceptable documents whenever possible**, but the Marketplace will take letters into consideration.

Resources on SEPV

New: 5 Things Assisters, Agents and Brokers Should Know about SVIs.

HealthCare.gov: click here to see a summary of SEPV for consumers

Model Notices: Click here to view sample EDNs, PPS notices, and other consumer notices. (Now available in both English and Spanish)

Submitting Documents:

- Click here to view documents consumers can submit to prove a loss of qualifying coverage.
- Click here to view documents consumers can submit to prove a move.
- Click here to view instructions for submitting documents online or by mail.

Presentation slides:

- SEPV Overview
- SEP Overview

Answers to Assister Questions

Q: Can consumers who need to send documents to prove SEP eligibility pick a plan before they send documents, and before CMS reviews their documents? SEP

A: Yes – consumers can pick a plan before sending the Marketplace documents to prove their eligibility. In fact, consumers **must** pick a plan before 60 days have passed since their SEP qualifying event. However, consumers' plan selection will be pended (put on hold) until they send documents and the Marketplace confirms their SEP eligibility.

Q: How long will consumers have to submit documents to the Marketplace to prove their SEP eligibility?

A: Consumers have 30 days after they pick a plan to submit documents to prove their SEP eligibility. This deadline will appear in the notice consumers receive after they pick a plan.

Remember: This deadline is the date by which they must submit required documents to the Marketplace. That is, this deadline is not also the date by which the Marketplace must verify consumers' SEP eligibility.

Q: How do I help consumers upload documents to their online accounts?

A: More information about how consumers can upload documents online to prove their SEP eligibility is available here on HealthCare.gov.

Uploading documents to their Marketplace account is the fastest way to get documents to us. However, consumers may also mail copies of their documents to the Marketplace if they prefer; information on how to send copies of documents by mail is available here. Remember, there is no option to fax documents or to send them by email.

Q: Is there anything consumers need to do after they submit documents to prove their SEP eligibility?

A: Once they've submitted documents to confirm their SEP eligibility, consumers should regularly check their Marketplace account, email, regular mail, and voicemail for more information from the Marketplace, because the Marketplace will follow up with more information on whether their documents successfully confirmed their SEP eligibility and, if not, information that they still need to confirm.

Consumers who have questions about the status of their documents can contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Q: Will consumers' Eligibility Determination Notices include information on which member of a household needs to submit documents to prove their SEP eligibility?

A: Yes – consumers must submit documents to prove SEP eligibility for at least one household member on their application who experienced the SEP qualifying event. Consumers Eligibility Determination Notice, Pended Plan Selection Notice, and other notices they receive related to their SEP will identify which member(s) of a household can submit information to prove their eligibility for the SEP.

Q: What happens if a consumer doesn't submit documents?

A: Consumers who don't respond to requests for documentation, or who don't provide sufficient documentation, could be found ineligible for their SEP and lose their opportunity to enroll in Marketplace coverage until the next annual open enrollment period or unless they experience another SEP qualifying event. If a consumer receives an Eligibility Determination Notice instructing him or her to submit documents to prove his or her eligibility for an SEP, it is critical that he or she submit the documents by the deadline listed in the Notice.

Remember: Consumers **have 30 days from when they choose a plan to submit documents that prove their SEP eligibility.** Consumers should read the EDN they get after they complete their application **and the notice they get after they pick a plan** carefully, and follow the instructions to resolve an SVI by their deadline.

Q: What if a consumer has a data matching issue (DMI) and also has to send documents to prove SEP eligibility?

A: If the consumer also has a data-matching issue (DMI, sometimes referred to as an "inconsistency") and therefore needs to submit other types of documents, their EDN will also include this information. Consumers who have a DMI can start using their coverage before they resolve their DMI, **but the consumer must still submit requested documents to keep their eligibility for Marketplace coverage and/or financial help.**

Consumers generally have 90/95 days from when they **complete their application** to submit documents to resolve a DMI, and 30 days **from when they pick a plan to submit documents to prove their SEP eligibility.**

If consumer has both a DMI and SVI then they'll need to resolve their SVI before they can begin using coverage. In some cases, this may occur before the DMI is resolved in which case the consumer could start using coverage prior to the DMI resolution. Visit HealthCare.gov/verify-information to learn more about how you can help consumers to resolve a DMI.

###

Medicare and Medicaid Updates

New Medicare Card

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, we said that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, we referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, we will refer to this project as the New Medicare Card.

To help you find information quickly, we designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1.

###

State Disproportionate Share Hospital Allotment Reductions (CMS-2394-P)

Today the Centers for Medicare & Medicaid Services (CMS) put on display at the Federal Register a proposed rulemaking (NPRM) regarding Medicaid Disproportionate Share Hospital (DSH) allotment reductions methodology to implement the annual reductions from FY 2018 through FY 2025.

To view the rule at the Federal Register (PDF) click here: https://www.federalregister.gov/d/2017-15962. For more information on Medicaid DSH Payments, visit https://www.medicaid.gov/medicaid/financing-and-reimbursement/dsh/index.html

###

May 2017 Medicaid and Children's Health Insurance (CHIP) Enrollment Data Available

The Centers for Medicare & Medicaid Services today posted the May 2017 monthly enrollment report detailing state Medicaid and Children's Health Insurance Program (CHIP) data. The report represents state Medicaid and CHIP agencies' eligibility activity for the calendar month of May 2017. The report can be found on the Medicaid website alongside reports for each month of 2017 and going back through 2013. Read additional background information about the monthly enrollment report.

###

Core Quality Measures Collaborative Pediatric Core Measure Set

On July 28, 2017, the Centers for Medicare and Medicaid Services (CMS) announced the release of a Pediatric measure set as part of the Core Quality Measures Collaborative (CQMC). This set of nine measures is intended for use at the provider level for individual or groups of clinicians and is intended to add focus to quality improvement efforts, reduce the burden of reporting of quality measures, and offer consumers actionable information for decision-making.

This release marks the next step forward for alignment of quality measures between public and private payers. Seven of the nine measures in this Pediatric set of quality measures are harmonized with existing state-level measures in the Medicaid and CHIP Child Core Set.

###

Market Saturation and Utilization Data Tool

The Centers for Medicare & Medicaid Services (CMS) has developed a Market Saturation and Utilization Data Tool that includes interactive maps and a dataset that shows national-, state-, and county-level provider services and utilization data for selected health service areas. Market saturation, in the present context, refers to the density of providers of a particular service within a defined geographic area relative to the number of the beneficiaries receiving that service in the area.

The fifth release of the data tool includes a quarterly update of the data to the ten health services areas from release 4, and also includes Long-Term Care Hospitals and Chiropractic Services data. Release 5 will therefore include five, twelve-month reference periods and the following health service areas: Home Health, Ambulance (Emergency, Non-Emergency, Emergency & Non-Emergency), Independent Diagnostic Testing Facilities (Part A and Part B), Skilled Nursing Facilities, Hospice, Physical and Occupational Therapy, Clinical Laboratory (Billing Independently), Long-Term Care Hospitals, and Chiropractic Services.

The Market Saturation and Utilization Data Tool can be used by CMS to monitor and manage market saturation as a means to prevent fraud, waste, and abuse. The data can also be used to reveal the degree to which use of a service is related to the number of providers servicing a geographic region. Provider services and utilization data by geographic regions are easily compared using an interactive map. There are a number of research uses for these data, but one objective of making these data public is to assist health care providers in making informed decisions about their service locations and the beneficiary population they serve. The tool is available through the CMS website at: https://data.cms.gov/market-saturation. Future releases may include comparable information on additional health service areas.

Methodology

The analysis is based on paid Medicare claims data from the CMS Integrated Data Repository (IDR). The IDR contains Medicare and Medicaid claims, beneficiary data, provider data, and plan data. Claims data are analyzed for a 12-month reference period, and results are updated quarterly to reflect a more recent 12-month reference period.

The Market Saturation and Utilization methodology is different from other public use data with respect to determining the geographic location of a provider. In this analysis, claims are used to define the

geographic area(s) served by a provider rather than the provider's practice address. Further, a provider is defined as "serving a county" if, during the 12-month reference period, the provider had paid claims for more than ten beneficiaries located in a county. A provider is defined as "serving a state" if that provider serves any county in the state.

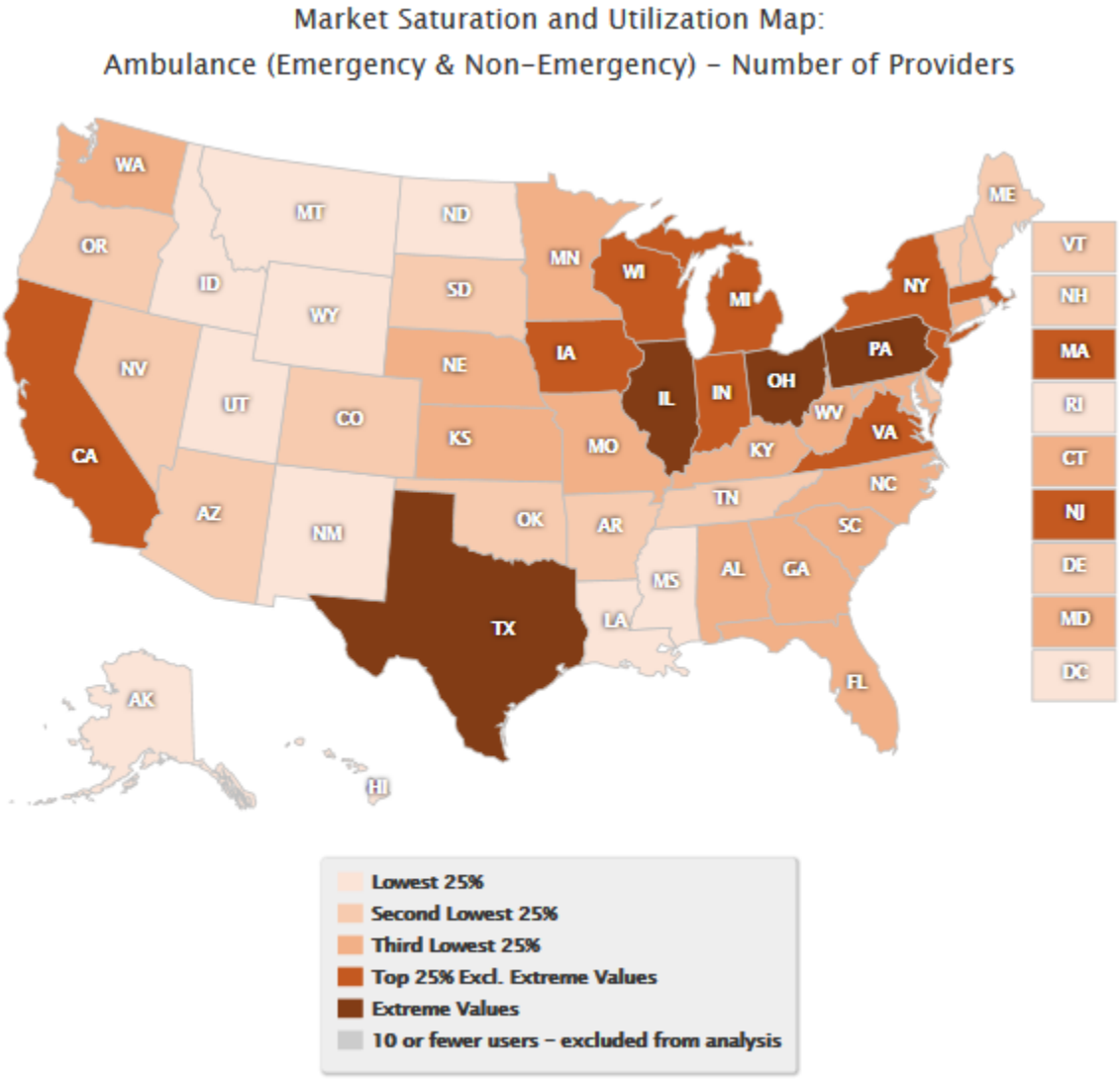
The Market Saturation and Utilization methodology is also different from other public use data with respect to determining the number of Medicare beneficiaries who are enrolled in a fee-for-service (FFS) program. In this analysis, a FFS beneficiary is defined as being enrolled in Part A and/or Part B with a coverage type code equal to "9" (FFS coverage) for at least one month of the 12-month reference period. There must not be a death date for that month or a missing zip code for the beneficiary so that the beneficiary can be assigned to a county. Other public use data may define a FFS beneficiary using different criteria, such as requiring the beneficiary to be enrolled in the FFS program every month during the reference period.

The Market Saturation and Utilization Data Tool includes an interactive map that is color-coded based on an analysis that separates the distribution into the following categories of states/counties for the selected metric: lowest 25 percent, second lowest 25 percent, third lowest 25 percent, top 25 percent excluding extreme values, and extreme values. An extreme value is one that greatly differs from other values in its field (e.g., Number of Providers). For those interested in states and counties affected by CMS' temporary provider enrollment moratoria during the reference periods for which data are available, the interactive map permits a visualization that identifies those states and counties. In this visualization, ambulance and home health service areas for moratoria versus non-moratoria states/counties are also identified based on color scheme. Counties that are excluded from the analysis are colored gray in the interactive map.

The examples below utilize the Ambulance (Emergency & Non-Emergency) service area data (selected for illustration purposes only). Similar maps can be created through the Data Tool for all of the health service areas included in the fifth release and for the five, twelve-month reference periods: 2014-10-01 to 2015-09-30, 2015-01-01 to 2015-12-31, 2015-04-01 to 2016-03-31, 2015-07-01 to 2016-06-30, and 2015-10-01 to 2016-09-30.

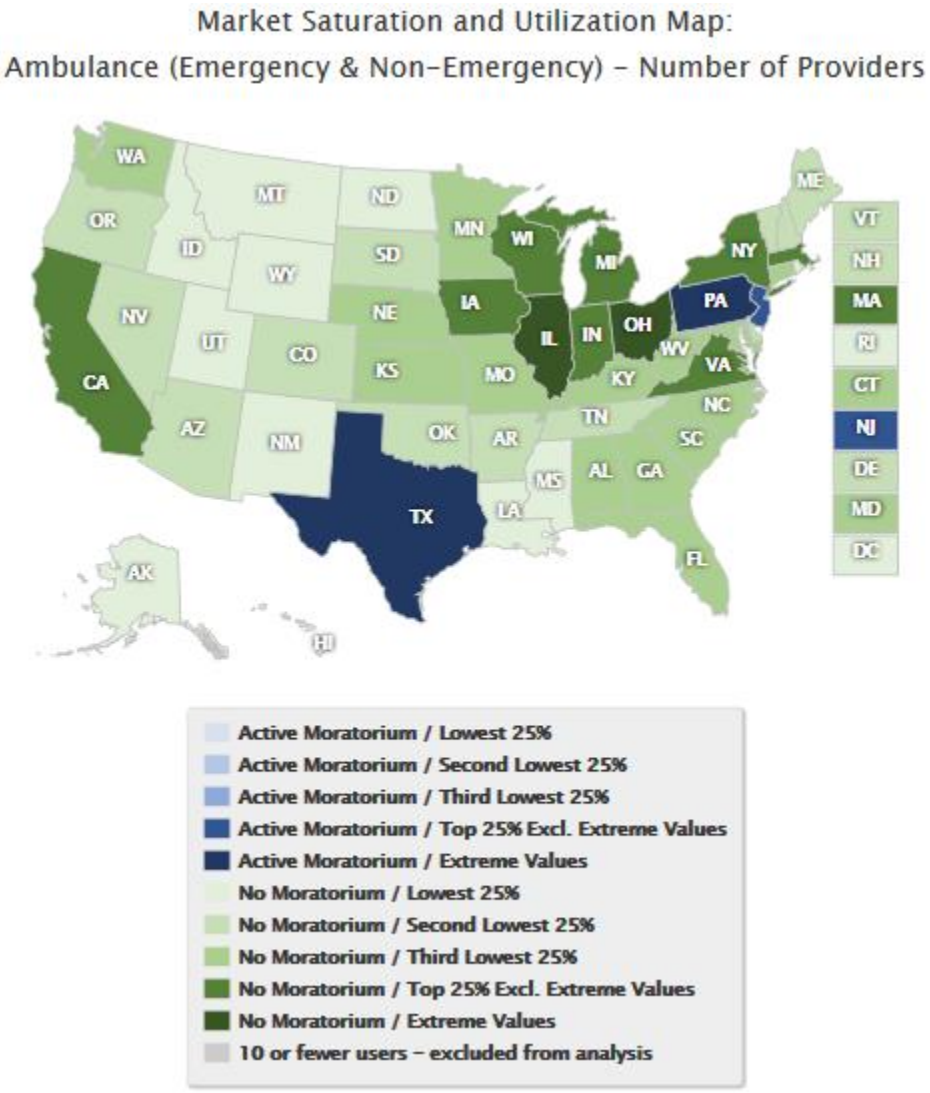
Map 1 displays the distribution of providers by state for the Ambulance (Emergency & Non-Emergency) service area for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a single color scale, which does not distinguish between moratoria and non-moratoria states.

Map 1. Ambulance (Emergency & Non-Emergency):
National Distribution of Number of Providers
October 1, 2014 – September 30, 2015
Single Color Scale



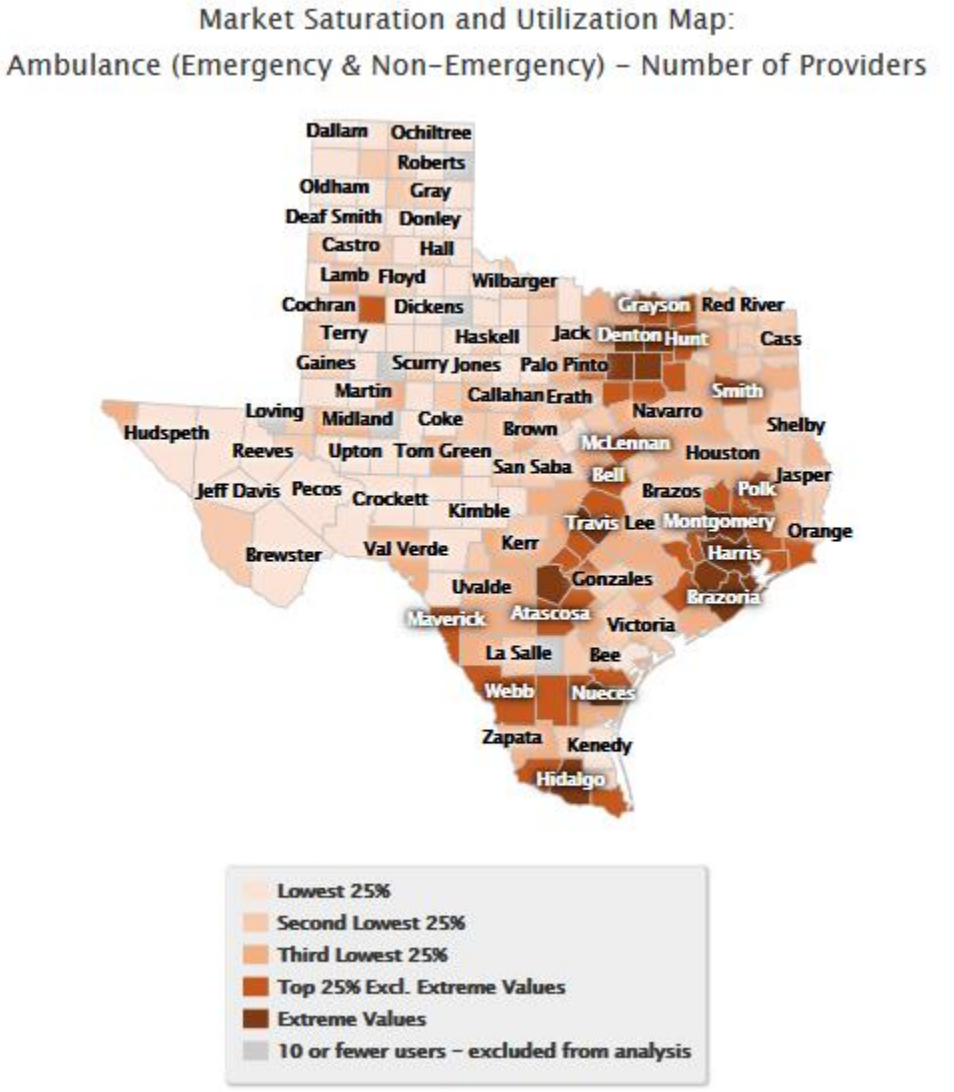
Map 2 displays the distribution of providers by state for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a dual color scale, which distinguishes between moratoria and non-moratoria states.

Map 2. Ambulance (Emergency & Non-Emergency):
National Distribution of Number of Providers
October 1, 2014 – September 30, 2015
Color by Moratoria Status



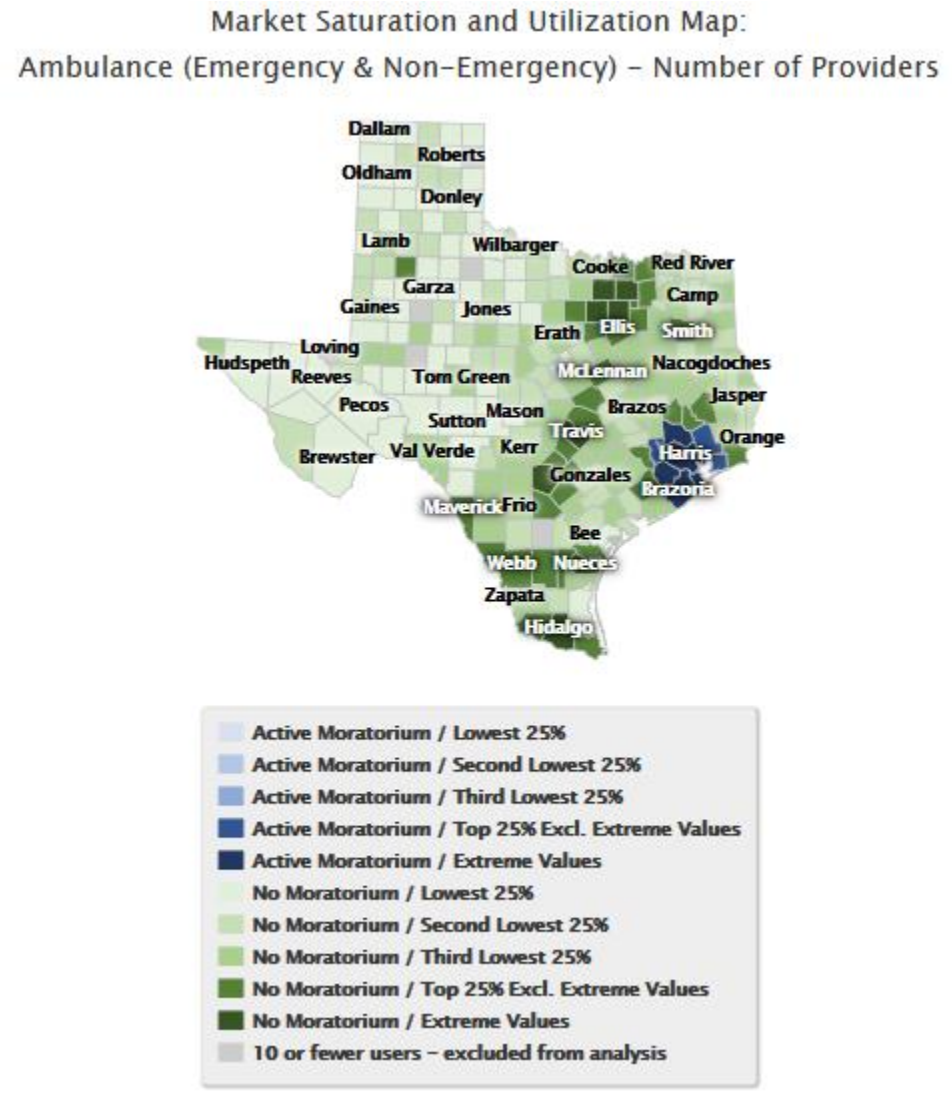
Map 3 drills down to the county level and displays the distribution of providers by county within the State of Texas for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a single color scale, which does not distinguish between moratoria and non-moratoria counties.

Map 3. Ambulance (Emergency & Non-Emergency):
County Distribution of Number of Providers
October 1, 2014 – September 30, 2015
Single Color Scale



Map 4 drills down to the county level and displays the distribution of providers by county within the State of Texas for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a dual color scale, which distinguishes between moratoria and non-moratoria counties.

Map 4. Ambulance (Emergency & Non-Emergency):
County Distribution of Number of Providers
October 1, 2014 – September 30, 2015
Color by Moratoria Status



Similar maps can be created at the national- and state-level for the other metrics included in the Data Tool: Number of FFS Beneficiaries, Average Number of Users per Provider, Percentage of Users out of FFS Beneficiaries, Number of Users, and Average Number of Providers per County.

###

October 2017 System Changes and Notices for Providers and Beneficiaries

In February 2017, CMS announced upcoming changes to CMS Fee For Service (FFS) systems intended to measurably stem the incidence of inappropriate QMB billing by helping providers more readily identify the QMB status of patients. Starting October 2017, CMS systems will be modified to clearly notify providers about each patient's QMB status and zero cost-sharing liability through new messages in the Provider Remittance Advice (RA). (Note: The RA is generated by CMS systems after claims are processed to inform the provider about what Medicare will pay and what the patient can be billed.) Additionally, the Medicare Summary Notice (MSN) will include messages and modifications to inform beneficiaries that they are enrolled in QMB and cannot be billed for Medicare cost-sharing.

To help SHIPS and advocates learn about these changes, CMS is sharing the attached mock-up of the revised MSN for Part B. (Note: the changes will also apply to MSNs for Part A). For more information about these changes, see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9911.pdf.

###

Medicare Trustees Report

The Medicare Trustees released their annual updated projections on the solvency of the program.

To find the **Secretary's remarks** (as prepared for delivery) from the Trustees press conference, visit: https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/2017-social-security-and-medicare-trustees-report-press-conference.html

To find a **press release** on the report, visit: https://www.hhs.gov/about/news/2017/07/13/medicare-trustees-report-shows-trust-fund-solvent-through-2029.html

To find a copy of the **Medicare Trustees report** – there will be some latency but the report will eventually be live here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html

IPAB non-triggered letter – again, there may be slight latency but will eventually be live here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/IPAB-Determination.html

###

Opioid Epidemic

HHS OWH Final Report on Opioid Use, Misuse, and Overdose in Women

The Office on Women's Health (OWH) released the *Final Report: Opioid Use, Misuse, and Overdose in Women*, which examines the prevention, treatment, and recovery issues for women who misuse, have use disorders, and/or overdose on opioids. This report synthesizes the work that OWH began in 2015 as part of the U.S. Department of Health and Human Services renewed commitment to address the opioid epidemic, including the findings of our 2016 National and Region I (New England) meetings. The report can be found here (online at www.womenshealth.gov/printables-and-shareables/federal-reports and www.womenshealth.gov/about-us/what-we-do/programs-and-activities).

Opioid use disorder is increasing at alarming rates for both men and women in the United States. While the crisis is being addressed at many different levels, much still needs to be done. The prevalence of prescription opioid and heroin use among women is substantial and the differences in how it impacts women and men are often not very well understood. In 2016, OWH convened experts and stakeholders to examine issues associated with the opioid epidemic through the lens of women's health. These meetings provided an opportunity to foster a national conversation about best practices in prevention and treatment for women, and supported a vigorous collaboration among researchers, public health practitioners, clinicians, policy makers, women with lived experience, and others to bring this epidemic to an end.

One facet of this epidemic where OWH has identified gaps is in meeting the primary and/or secondary prevention of prescription and non-prescription opioid misuse by women across the lifespan, including girls ages 10-17 and women age 50 and older. In recognition of the needs of this population, OWH will soon enter into cooperative agreements with public and private nonprofit entities across the nation working on the frontlines of this epidemic. The programs supported by these grants will apply a gender-responsive approach to addressing primary and/or secondary prevention of prescription and non-prescription opioid misuse among women.

###

Upcoming Webinars and Events and Other Updates

2017 Medicare National Training Program (NTP) Workshops

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office invites you to attend the **2017 Medicare National Training Program (NTP) Workshops**.

This year we are pleased to offer the Workshop in 4 different locations. The same agenda and information will be provided at all Workshops.

When and Where

Kansas City, MO
Wednesday, August 9, 2017 12:30PM – 5:00PM to Thursday, August 10, 2017 8:00AM – 4:30PM
Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-kansas-city-tickets-35821672587

St. Louis, MO Area
Monday, August 14, 2017 12:30PM – 5:00PM to Tuesday, August 15, 2017 8:00AM – 4:30PM
Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-st-louis-area-registration-35433070267

Lincoln, NE
Thursday, August 24, 2017 12:30PM – 5:00PM to Friday, August 25, 2017 8:00AM – 4:30PM
Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-lincoln-tickets-35823187117

Des Moines, IA
Tuesday, August 29, 2017 12:30PM – 5:00PM to Wednesday, August 30, 2017 8:00AM – 4:30PM

Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-des-moines-tickets-35823465951

Topics to be covered are:

- Medicare 101 - Explains the Medicare Program including what it is, coverage and costs, coverage choices, enrollment, coordination of benefits, and how to fight fraud and abuse.
- Medicare Supplement Insurance (Medigap) Policies - Explains how Medigap policies work with Medicare, what Medigap policies cover, how they are structured, and when to buy a Medigap policy.
- Medicare Advantage - Explains Medicare health plan options other than Original Medicare.
- Medicare Prescription Drug Coverage - Provides an overview of Medicare prescription drug coverage under Part A (Hospital insurance), Part B (Medical Insurance), and Part D (Prescription Drug Coverage).
- Medicare and Other Programs for People With Disabilities/SSA - Explains Medicare, Social Security benefits and other programs for people with disabilities.

- Medicare and Medicaid Fraud and Abuse Prevention - Explains Medicare and Medicaid fraud and abuse prevention, detection, reporting, recovery and the Office of the Inspector General's role in fighting healthcare fraud including showcasing resolved fraudulent Medicare and Medicaid cases.
- CMS' Approach to Combating the Opioid Epidemic - Explains CMS' goals, scope and focus on the misuse of opioids.
- Medicaid and the Children's Health Insurance Program - Describes eligibility, benefits, and administration of Medicaid; Define eligibility, benefits, and administration of the Children's Health Insurance Program (CHIP).
- Casework - Hands-on experience working through case scenarios pertaining to Medicare Parts C & D.
- Current Topics - Explains new policies, innovations, and legislation.
- CMS Program Resources - Outlines key websites, associated resources, and tools for the programs administered by CMS—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.
- Opportunities to network with CMS staff and subject matter experts and other organizations working with the Medicare/Medicaid population.

As always, there will be no charge to you for the training; however, CMS will not be able to provide food or drinks.

We will be providing materials electronically to attendees prior to the Workshop. Attendees will be responsible for bringing any hard copies of materials they would like, or have access to them electronically on their own personal device. Please make sure your email address in your registration is correct.

In addition, if you register for a Workshop and then later determine you are unable to attend, please access Eventbrite and cancel your ticket so others can attend. Those who register and do not attend may be placed on a wait list for future CMS events.

We look forward to your participation. If you have any questions or have difficulty registering, please contact Lorelei Schieferdecker at Lorelei.schieferdecker@cms.hhs.gov.

###

IRF Quality Reporting Program Refresher Training Webinar

Tuesday, August 15, 2017 - 2:00pm to 4:00 pm ET

CMS is hosting a webinar for IRF providers. Visit the IRF Quality Reporting Training webpage for more information and to register.

###

Medicare Learning Network Publications & Multimedia

News & Announcements

- Home Health Agency CoP Final Rule: Effective Date Extended to January 13, 2018
- Hospice Quality Reporting Program: Non-Compliance Letters
- IRF Quality Reporting Program: Non-Compliance Letters
- LTCH Quality Reporting Program: Non-Compliance Letters
- SNF Quality Reporting Program: Non-Compliance Letters
- IRF, LTCH, and SNF Quality Reporting Program Data due August 15
- New PEPPER Available for Home Health Agencies and Partial Hospitalization Programs
- Hospitals: 2018 QRDA Category I Implementation Guide
- Health Care Fraud Takedown: Charges Against Individuals Responsible for $1.3 Billion in Fraud

- Home Health Agencies: CMS Proposes 2018 and 2019 Payment Changes
- New Medicare Card (formerly called SSNRI)
- Quality Payment Program: Explanation of Special Status Calculation
- Updated CMS Measures Inventory Posted
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis
- Anniversary of the American Disabilities Act

Provider Compliance

- Billing For Stem Cell Transplants
- Hospital Discharge Day Management Services CMS Provider Minute Video

Claims, Pricers & Codes

- 2018 ICD-10-CM POA Exempt Codes Available

Upcoming Events

- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments Listening Session — August 1
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22
- CMS National Provider Enrollment Conference — September 6 and 7

Medicare Learning Network Publications & Multimedia

- Quality Payment Program Listening Session: Audio Recording and Transcript — New
- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool — New
- Medicare Basics: Parts A and B Claims Overview Video — Reminder
- Chronic Care Management Services Fact Sheet — Reminder
- Quality Payment Program 2017 MIPS: Improvement Activities Performance Category Web-Based Training Course — New
- Provider/Supplier Enrollment Call: Audio Recording and Transcript — New
- Medicare Part B Immunization Billing Educational Tool — Reminder

###

New Publications

- Coordination of Benefits: Getting Started
- How Medicare Prescription Drug Coverage works with a Medicare Advantage Plan or Medicare Cost Plan
- Key Dates for the Health Insurance Marketplace
- Key Dates for the Health Insurance Marketplace – Spanish
- Marketplace Call to Action Conference Card
- Marketplace and Young Adults Poster
- Need affordable health insurance? Card - Spanish
- About the Health Insurance Marketplace

- The Value of Health Insurance
- Your Guide to Choosing a Nursing Home or Other Long-Term Care
- Get help with your Medicare Costs: Getting Started
- Your Guide to Medicare Prescription Drug Coverage
- What To Do If You No Longer Automatically Qualify For Extra Help With Medicare Prescription Drug Coverage Costs
- Choosing a Medigap Policy

###

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.