CMS Region 7 Updates

02/24/2016

Marketplace Updates

New: Failure to Reconcile Special Enrollment Period (SEP)

On February 5, 2016 the Centers for Medicare & Medicaid Services (CMS) provided information about a special enrollment period (SEP) for consumers who:

- are not currently enrolled in 2016 coverage through the Federally-facilitated Marketplace (FFM),
- are not receiving advance payments of the premium tax credit (APTC) in 2016 because they failed to file a tax return for 2014 and reconcile their APTC, and
- subsequently filed their 2014 tax return and reconciled their 2014 APTC.

This SEP will only be available to consumers after they restore their eligibility for APTC by filing a 2014 tax return, reconciling APTC paid on their behalf in 2014, and returning to the Marketplace to attest to having filed and reconciled 2014 APTC.

For more information copy and paste the following link in your b
browser: **https://www.regtap.info/uploads/library/ENR_FTR_SEP_Guidance_020516_5CR_020516.pdf**

###

Tax Season Spotlight

Key Takeaways: The Marketplace mailed all 1095-A Forms by February 1, 2016. The deadline for insurers, other coverage providers, and certain employers to provide Forms 1095-B and 1095-C has been extended to March 31, 2016. Consumers expecting to receive a Form 1095-A should wait to file their 2015 income tax return until they receive that form, but it is not necessary to wait for Forms 1095-B or 1095-C in order to file. Also, advise consumers to carefully select the tax preparers they employ to help file their taxes.

###

Form 1095-A is Now Available to Consumers

The Form 1095-A is now available to consumers who enrolled in coverage through the Health Insurance Marketplace. Consumers should receive a hard copy of this form in the mail, but can also access the form directly through their healthcare.gov account in the tax form section. If consumers do not have online accounts, they can create one to view their Form 1095-A. Depending on changes that may have occurred to consumers' coverage over the course of 2015, such as changing Marketplace plans during the year, some consumers may receive more than one Form 1095-A.

Please remember that as an assister, you are prohibited from helping consumers with filing their taxes unless you are also a licensed tax professional.

Let consumers know that the monthly enrollment premium listed on their Form 1095-A (Part III, Column A) may be different from their plan's full monthly premium amount. This doesn't always mean there are errors that need to be corrected. The monthly premium on the Form 1095-A may be different from what is expected for several reasons that are addressed here. If consumers identify errors on their Form 1095-A, direct them to notify the Marketplace by calling the Marketplace call center. Below are some helpful resources to share with consumers as you help them understand how the receiving of APTC's for their Marketplace coverage affects their taxes. Click the hyperlink to access the resource:

Complete guide to 2015 health coverage & your tax status

- Complete guide to 2015 health coverage & your tax status
- Health Coverage Tax Tool
- How to Use Form 1095A
- How to Reconcile PTC

Remind consumers that they may receive one or more forms providing information about the health care coverage that they had or were offered during 2015. Much like Form W-2 and Form 1099, which include information about the income individuals received, these health care forms provide information that consumers may need when they file their individual income tax return for 2015.

The new health care information forms for individuals are the Forms 1095-A, 1095-B, and 1095-C. Questions and Answers about Health Care Information Forms for Individuals (Forms 1095-A, 1095-B, and 1095-C) can be accessed here.

###

Helping Consumers Avoid Tax Fraud

In your work with consumers, please let them know that there are reports of consumers being targeted by tax scams. If consumers owe a payment, let them know that payment should be made only with their tax return or in response to a letter from the IRS. The payment should never be made directly to an individual or tax preparer.

Also, let consumers know that if they are not U.S. citizens or nationals, and are not lawfully present in the United States, they are exempt from the individual shared responsibility provision and do not need to make a payment. For this purpose, immigrants with Deferred Action for Childhood Arrivals (DACA) status are considered not lawfully present and are therefore exempt.

Below is additional information to share with consumers that can help prevent them from being victims of fraud. Click the hyperlink to access the resource:

- Affordable Care Act Consumer Alert: Choose Your Tax Preparer Wisely
- Affordable Care Act Consumer Alert: Choose Your Tax Preparer Wisely (Spanish Version)
- Tips for Choosing a Tax Professional
- Make a Complaint About a Tax Return Preparer

###

Marketplace Update: Important Application Tips for working with Immigrants

Key Takeaways: If a consumer's Alien ID is 7 digits or 8 digits long, add a 0 or 00 before the ID number to make the Alien ID 9 digits long.

Consumers should enter their immigration document information to make the application process go more smoothly and to avoid data matching issues.

Reassure consumers that immigration information will only be used for Marketplace and insurance affordability programs. Understandably, some non-citizens are hesitant to apply because they fear the information on their application will be shared with immigration authorities. Please reassure customers that their information will NOT be used for immigration enforcement activities.

###

New Tip for Eligible Immigrants to Enter Alien Number ("A-Number") on the Application

It is important to enter consumers immigration document information (such as Alien Number ("A-Number" or I-94 Number), if applicable. Some consumers may have an alien number that is exactly 9 digits long, while some individuals have an older Alien number that is only 7 or 8 digits long. An applicant with an Alien number that is 7 or 8 digits should add 1 or 2 zeroes ("0" or "00") at the beginning so the A-number is 9 digits long. Entering a 9-digit Alien number will prevent an error message and reduce the likelihood that a consumer will experience an immigration status data matching issue and/or will have to submit documents later. Assisters can use this tip to help consumers include their document number on their application. Also, you should encourage applicants to include as much information as possible about their immigration status and household information, which will help increase the likelihood of a successful application submission.

###

Assisters Should Help Consumers Enter Document Numbers

Consumers with an eligible immigration status may be able to electronically verify their status during the application process using only an alien number ("A-Number") or an I-94 number, instead of providing multiple document numbers. If a consumer has immediate access to all of the document numbers, we recommend that they select their specific document in the drop-down list and enter all of the numbers requested. While it is possible to use just one number, the system will produce better verification results if all of the numbers are provided.

We have heard that some assisters believe that entering a consumer's immigration document information (such as their "A-Number" or I-94 Number) will prevent an application from being successfully submitted. The opposite is true: including document numbers on the application will help a consumer submit the application successfully. Entering immigration document information will NOT prevent a consumer from completing the application or give the consumer a yellow error screen. In the past, a Marketplace system error caused consumers to see a "yellow screen" at the end of the application which blocked their application submission, and consumers were told to use a different path to enter their documents. We fixed the issues causing the error screen in 2014. Today, entering immigration document information will make the application process go smother and faster, and reduce the chances the consumer will experience a data matching issue.

###

The Facts about the Affordable Care Act and Enforcement

Affordable coverage options are available in the Health Insurance Marketplace for immigrant families. Share these facts with immigrant consumers about getting coverage:

- Mixed status families can apply for a tax credit or lower out-of-pocket costs for private insurance for their dependent family members who are eligible for coverage in the Marketplace or for Medicaid and CHIP coverage. Family members who aren't applying for health coverage for themselves won't be asked if they have eligible immigration status.
- Federal and state Marketplaces, and state Medicaid and CHIP agencies can't require consumers to provide information about the citizenship or immigration status of any family or household members who aren't applying for coverage.
- States can't deny consumers benefits because a family or household member who isn't applying hasn't provided his or her citizenship or immigration status.
- Information that a consumer provides to the Marketplace won't be used for immigration enforcement purposes.

Additional Resources on Eligibility and Application Help for Immigrant Families:

- Immigrants Fast Facts for Assisters
- Citizenship & Immigration Questions on the Marketplace Application
- More resources on Marketplace.CMS.gov, technical resources, special populations are available here

###

Authorized Representatives and Third Party Representatives

Key Takeaways: CMS has temporarily suppressed the "authorized user" page that was previously available in a consumer's My Account. Consumers cannot currently appoint formal authorized representatives through either the online or paper applications. Help consumers understand the two different types of representatives (authorized representatives vs. third-party representatives) so they can make informed choices about who speaks or acts on their behalf.

Because of a system defect, consumers cannot currently appoint formal authorized representatives through either the online or paper applications. To avoid confusion, the "authorized user" page won't be visible until CMS can fully implement the appropriate functionality. This does not affect the information that consumers enter about who assisted them in the application.

As a reminder, for Call Center purposes only, a consumer can designate an individual as a third-party representative to communicate with the Marketplace Call Center on the consumer's behalf. Please refer to slides 13 and 14 of the How Assisters Can Help Consumers Apply for Coverage through the Marketplace Call Center presentation for information on how consumers can designate someone to speak to the Call Center on their behalf. Communicate to consumers that the major difference between allowing an assister to act as a third-party representative and the designation of an authorized representative is that acting as a third-party representative does not allow the assister to make decisions on behalf of the consumer, which includes selecting a plan or filing an appeal on behalf of the consumer.

These roles are not interchangeable, so if a consumer designates someone to act in one capacity—in an appeal, for example—it does not mean that person has been designated in another capacity—such as to communicate with the Marketplace Call Center. Each type of designation must be done separately, and consumers may not want the same person in each role. You can help consumers understand these

different types of representatives so they can make informed choices about who speaks or acts on their behalf.

###

Employer Sponsored Coverage Complex Scenario

Consumers who transition from part- to full-time hours and are now eligible for Employer Sponsored coverage (ESC) outside of their employer's open enrollment should answer "yes" to the question of whether they have an offer of ESC in the Marketplace application.

Key takeaways:

- For consumers who transition from part- to full-time hours, and assuming consumers' employers have this option, employers should offer consumers a SEP for their ESC to enroll in a health plan.
- If consumers still want to enroll in a Marketplace plan on Healthcare.gov during open enrollment, they should answer "yes" to the question of whether they have an offer of ESC. Consumers will need to note on the Marketplace application that they're eligible for coverage beginning on the date that the ESC would start.
- ***Please note:*** consumers with ESC can buy a plan through the Marketplace, but will pay full price unless the employer's insurance does not meet certain standards.
- If consumers are not offered a SEP for their employer's sponsored coverage, consumers should still answer "yes" to the question of whether they have an offer of ESC. Consumers will need to note when they will be eligible for ESC in the subsequent question on the Marketplace application.

For more information on ESC, click here.

###

Removing Household Members

If an applicant wants to remove a household member from his/her application, especially if the household member is no longer a dependent, the applicant will need to report a life change. The applicant will log into his/her HealthCare.gov account, select "report a life change", select the option that says "remove a household member" and follow the subsequent prompts to remove the household member(s) off the application. Please note that when consumers end coverage for just some people on their application, their premium tax credit or other savings may change. Also note that when consumers remove only some people from coverage on the application, and others stay enrolled, the loss of coverage will be effective immediately.

For more detailed instructions on how consumers can make updates when their household changes, click here.

###

Payment is Required to Complete Plan Enrollment

We encourage assisters to remind consumers that they must select a plan and submit their first premium payment in order to confirm enrollment. Specifically, consumers should:

- Check with their insurance company to find out when their first premium is due. It is also important to remember that the actual deadline for when the first premium is due varies among insurance companies.
- Pay their contribution to the first month's premium (and every premium when it is due) to their plan directly – not to the Marketplace.

- Carefully review their member card and/or other materials the plan sends to them. This should include confirming which members of the household will be covered by the plan.
- Contact their plan with any questions and/or if they don't receive a member card.

Marketplace.CMS.Gov Resources

Periodically check out the marketplace.cms.gov website for posting of new resources that will be helpful for your work in assisting consumers! New Eligibility and Enrollment Resources include:

- 2015 Tax Season Kickoff
- Modified Adjusted Gross Income (MAGI) 101
- Assisting Consumers with Behavioral Health Conditions
- Update to FFM Functionality for Immigrants with Incomes Under 100% FPL
- Tips to Resolve Outstanding Data Matching Issues (Inconsistencies)

Don't forget that CMS now archives recordings and written transcripts of its assister webinars as well as past assister newsletters

###

Assister Help Resource Center Open Through April 15th

The AHRC will be opened from February 1- April 15 from 9am -6pm EST Monday to Friday. Assisters can reach AHRC via telephone at 855-811-7299 as they conduct their post-enrollment activities such as helping consumers with 1095-A forms and SEP. The Assister Help Resource Center will not be open on Presidents Day (February 15).

###

Answers to Questions from Assisters

Q: *How will consumers access their Form 1095-A?*

A: Consumers can access their 1095-A forms two ways. If consumers have a HealthCare.gov account they can access their form 1095-A online in the "tax forms" section in their account. The FFM also sent consumers a paper copy of their Form 1095-A in an envelope labeled "Important Tax or Health Coverage Information Inside". This envelop contains a cover letter, Form 1095-A instructions, and the consumer's Form 1095-A.

If a consumer created an application over the phone through the Call Center or sent in a paper application through the mail, and does not have a HealthCare.gov account, the consumer can create an account, complete ID proofing, and then use the "Find Application" function to associate his or her existing application with the online account. Each account holder can attempt to find an application three times per day, for security purposes. Consumers will need to have their application ID number to retrieve their application online. Consumers who are not sure of their application ID can call the Marketplace Call Center to obtain it. The Call Center will ask for some information to verify each consumer's identity, such as the full name listed on the consumer's application, his or her address, social security number, date of birth, or phone number.

Also remember that some consumers that made changes to their coverage during 2015 may receive more than one 1095-A.

Q: *Last year some consumers received incorrect Form 1095-As. Did incorrect Form 1095-As go out this year as well?*

A: At this time CMS has not identified any errors during notice/form production. However, consumers who identify potential, individual, errors specific to their policy should call into the Marketplace Call Center and submit an inquiry.

Q: *Will consumers enrolled in Medicaid receive a Form 1095-A?*

A: No. The Marketplace sends Form 1095-A to individuals who enrolled in Marketplace coverage, with information about the coverage, who was covered, and when. Consumers who are enrolled in Medicaid will receive a Form 1095-B. For more information on who will produce and who will receive different forms please view IRS Q&A.

###

Third Party Representatives For non-English Speaking Consumers

Q: *Can assisters translate for consumers with limited English proficiency when calling the Marketplace Call Center?*

A: Yes. Assisters can serve as an interpreter for a consumer with limited English proficiency to communicate with the Marketplace Call Center; however the consumer must first authorize the assister as a third-party representative in his or her native language. To do so, the consumer must call the Marketplace Call Center with his or her third-party representative and request to be connected to the language line for assistance from an interpreter. Upon reaching the interpreter, the consumer can give verbal authorization for the third party representative to speak on his or her behalf. The interpreter will translate the authorization to the Marketplace Call Center representative. (Note: Before collecting the authorization, the Marketplace Call Center will ask the consumer for identifying information such as first and last name, state, Social Security and/or telephone number). Once the Marketplace Call Center obtains the verbally-translated authorization, the authorization can last for up to 365 days unless the consumer calls back to remove the authorization.

Q: *In a family of two (e.g. mother and tax dependent child), if their only income is Social Security survivor benefits, does the total count towards MAGI or does the child's income not count?*

A: If the tax dependent's only income is from Social Security, then his or her income would not be counted toward the household income. However, if the tax dependent has additional earned or unearned income that gives them a requirement to file a federal income tax return, then all his or her income would be counted toward the household, including the Social Security income. The Marketplace application will automatically determine whether to count a tax dependent's income toward the household income. Enter the tax dependent's income and the system will determine whether to count it. See IRS Publication 501 for more information on the income thresholds for tax dependents.

Q: *I see families in our area continue to struggle with situations where grandchildren are being denied Medicaid due to their custodial grandparents' income. I am looking for a resource to be able to share with our local DHS caseworkers to help them understand the exception to the regular MAGI rules.*

A: Custodial grandparents should not be included as members of the children's Medicaid household, and the grandparents' income should not be counted toward the child for purposes of determining Medicaid eligibility. The Medicaid MAGI definition of "child" means biological/natural, adopted, or stepchild. Grandchildren are not considered their grandparents' children, even if the grandparents have custody or guardianship. Persons who are neither the spouse nor the child of the tax filer who claims them as a tax dependent have their Medicaid household determined under the "non-filer rules." For example, assuming the child is under the age 19 (or 21 and a full time student, depending on the state), the "non-filer rules" includes the child, plus any spouse, parent(s), siblings or children that the child lives with. For more information, see pages 61-62 of NHeLP's Advocates Guide to MAGI (Section IV.C.2.b.(i) – "Individuals other than a spouse or a child who expect to be claimed as a tax dependent by a tax filer"). Remember that this is different from the rules for determining eligibility for advance payments of the premium tax credit or

cost-sharing reductions through a qualified health plan, which is based on the tax household (e.g., tax filers and tax dependents), and might include custodial grandparents.

Q: *What is the rule for lawfully present consumers who earn less than 100% of the Federal Poverty Level (FPL) and have not been in the US long enough to be eligible for Medicaid? Are they eligible for APTC?*

A: In general, an applicant must have an annual household income between 100% and 400% of the FPL in order to be eligible for APTC or CSRs. However, lawfully present immigrants who are not eligible for Medicaid based on their immigration status may be eligible for APTC and CSRs even if their annual household income is under 100% of FPL. For more information, please see this page on HealthCare.gov.

Q: *Does MAGI apply to CHIP programs in non-Medicaid expansion states?*

A: Yes. A state's decision whether or not to extend Medicaid coverage for low-income adults is not related to the use of MAGI. MAGI applies to most eligibility categories for Medicaid and CHIP, except individuals age 65 and older when age is a condition of eligibility, those who qualify for Medicaid based on disability, or where the state does not conduct an income determination (e.g., children in foster care and former foster youth). Note that MAGI applies when determining if an individual qualifies in the parent/caretaker relative category, even if the applicant is over age 65.

Q: *Where can I find SAMHSA information about the ACA?*

A: Information about the ACA and related health reform and financing topics can be found on the following SAMHSA webpages:

- Health Care and Health Systems Integration
- Health Financing
- Laws, Regulations and Guidelines

For any questions that are not answered by the information contained in these pages, please contact Mariel Lifshitz, Mariel.Lifshitz@samhsa.hhs.gov

###

Standing Assister Resources

Below are some resources that assisters use on a regular basis.

- Marketplace.CMS.gov Page
- Find Local Help
- HealthCare.gov Website
- IRS Affordable Care Act Tax Provisions Page

###

Marketplace Call Center and SHOP Call Center Hours

Health Insurance Marketplace Call Center**:** For customer service support, to start or finish an application, compare plans, enroll or ask a question. 1-800-318-2596 (TTY: 1-855-889-4325). Available 24 hours a day, 7 days a week. Closed Memorial Day, July 4th, and Labor Day.

SHOP Call Center**:** For customer service support, including assisting employers and employees apply for and enroll in SHOP. 1-800-706-7893 (TTY: 711). Available M-F 9:00 am-7:00 pm EST. Closed New Year's Day, Martin Luther King Day, Memorial Day, July 3rd, Labor Day, Veterans Day, Thanksgiving and the day after, and Christmas.

###

Stay in Touch

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

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

- For **HHS Navigator grantees** - please get in touch with your Navigator Project Officer or send a request to navigatorgrants@cms.hhs.gov.
- For **CAC Designated Organizations in FFM or SPM states** - please send an email to CACQuestions@cms.hhs.gov.

Follow @HealthCaregov Twitter with the hashtag #ACAassisters for updates, reminders, and new publications for assisters.

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

Please note that the information provided above from the Assister Newsletter is informal, technical assistance for assisters and is not intended as official CMS guidance.

###

Strengthening Provider and Supplier Enrollment Screening

The Affordable Care Act (ACA) provided tools to enhance the Centers for Medicare & Medicaid Services' (CMS) ability to screen providers and suppliers upon enrollment and identify those that may be at risk for committing fraud, including the use of risk-based screening of providers and suppliers. In addition to implementing the tools provided by the ACA, CMS is strengthening strategies designed to reinforce provider screening activities by increasing site visits to Medicare-enrolled providers and suppliers, enhancing and improving information technology (IT) systems, and implementing continuous data monitoring practices to help make sure practice location data is accurate and in compliance with enrollment requirements.

A recent report by the Government Accountability Office (GAO) reviewed the implementation of some of CMS' screening procedures that are used to prevent and deter ineligible or potentially fraudulent providers and suppliers from enrolling in the Medicare program. The GAO concluded that, as part of an overall effort to enhance program integrity and reduce fraud risk, effective enrollment and screening procedures are essential to make sure that ineligible or potentially fraudulent providers and suppliers do not enroll in the program and that CMS has taken steps to develop and implement such procedures. The GAO analysis identified areas for improvement in our Provider Enrollment Chain and Ownership System (PECOS) regarding verification of provider and supplier practice locations and physician licensure statuses. Providers and suppliers are required to supply the address of the location from which services are offered on their Medicare enrollment applications.

The GAO's findings supported CMS' efforts to further enhance provider and supplier screening activities. CMS has begun increasing site visits to Medicare-enrolled providers and suppliers, enhancing and improving IT systems and implementing continuous data monitoring practices to help make sure practice location data is accurate and in compliance with enrollment requirements.

Summary

CMS is strongly committed to protecting the integrity of the Medicare program, including making sure providers and suppliers enrolled in Medicare are qualified and legitimate. The Affordable Care Act provided tools to enhance our ability to screen and identify those providers and suppliers that may be at risk for committing fraud. In our effort to continuously enhance Medicare program integrity and use information identified by the GAO, CMS is strengthening strategies designed to reinforce provider screening activities, specifically:

1. Utilizing the National Site Visit Contractor (NSVC) to increase the number of site visits to Medicare-enrolled providers and suppliers;
2. Enhancing address verification software in PECOS to better detect vacant or invalid addresses or commercial mail reporting agencies (CMRA);
3. Analyzing enrollment data to allow us to identify and deactivate providers or suppliers meeting specific criteria that have not billed Medicare in the last 13 months; and
4. Monitoring and identifying potentially invalid addresses on a monthly basis through additional data analysis by checking against the U.S. Postal Service address verification database.

Background

Section 1866(j) of the Social Security Act (the Act)) requires the Secretary to establish an enrollment process for Medicare providers and suppliers. Providers and suppliers enrolled in the Medicare program have specific obligations to, among other things, notify CMS of any address, licensure or other changes that may impact enrollment (42 C.F.R. § 424.516). Maintaining accurate addresses of the location from which providers and suppliers offer services is vital to protecting the integrity of the enrollment process.

Increasing the Number of Site Visits

CMS has the authority, when deemed necessary, to perform onsite review of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements (42 C.F.R. 424.517). Under this authority, CMS is now increasing site visits, initially targeting those providers and suppliers receiving high reimbursements by Medicare that are located in high-risk geographic areas.

CMS believes that increasing site visits, improving IT systems, and conducting continuous data monitoring will strengthen the integrity of the Medicare program while minimizing burden on the provider community. CMS will continue to advise the provider and supplier community of the importance of maintaining accurate, up-to-date provider enrollment practice location information. It is important that the provider community continue to inform CMS of any changes to their enrollment, as required.

System Enhancements & Updated Processing Direction

CMS will also replace the current PECOS address verification software with new software starting in CY2016 that not only includes the existing functionality but also Delivery Point Verification (DPV). This new DPV functionality will flag addresses that may be vacant, CMRAs or invalid addresses. These verifications will take place during the application submission process and may trigger ad hoc site visits.

Continuous Data Monitoring

On a monthly basis, CMS will run additional analyses on enrollment data to deactivate providers or suppliers meeting specific criteria that have not billed Medicare in the last 13 months. CMS may exclude providers and suppliers from deactivation for non-billing, including: those enrolled solely to order, refer, and prescribe or certain specialty types, e.g. pediatricians, dentists and mass immunizers (roster billers). This

approach will remove providers and suppliers with potentially invalid addresses from PECOS without requiring site visits.

CMS now continuously monitors and identifies addresses that may have become vacant or non-operational after initial enrollment. This monitoring is done through monthly data analysis that validates provider enrollment practice location addresses against the USPS address verification database.

###

FACT SHEET: Announcing the Winner of the Healthy Communities Challenge

The Department of Health and Human Services (HHS) announced that nearly 13 million Americans selected a 2016 Marketplace plan during the third open enrollment period under the Affordable Care Act. This year's successful open enrollment builds on recent years of rapid progress in expanding access to health insurance coverage, which has pushed the nation's uninsured rate below 10 percent for the first time ever. These gains are thanks in large part to the efforts of local and state elected officials, community organizations and leaders, and volunteers who have worked tirelessly to help their neighbors find access to quality, affordable coverage.

Today, the White House is announcing that the winner of the White House "Healthy Communities Challenge" is Milwaukee, Wis. Under the leadership of Mayor Tom Barrett and County Executive Chris Abele, about 38,000 people in the Milwaukee area newly selected a plan through the Health Insurance Marketplace during this open enrollment period. Together with returning Marketplace consumers, about 89,000 people in the Milwaukee area selected a 2016 Marketplace plan. Altogether, participating communities saw over 1.6 million new enrollees, representing the people where were uninsured for years as well as Americans finding coverage as they go through changes in life such as being in between jobs, striking out as entrepreneurs, or aging off their parents' plans. Many more consumers renewed their previous Marketplace coverage.

Chicago, Ill.; Atlanta, Ga.; Detroit, Mich. and Oakland, Calif. rounded out the top five for the Challenge. As the victorious community, Milwaukee receives bragging rights, a healthier community, and a visit from President Obama to celebrate their success in helping ensure Americans have health coverage. President Obama will visit Milwaukee in the coming weeks.

President Obama said, "I congratulate Milwaukee, and all of the other communities who took part in the challenge, for their passion and innovation in finding ways to make sure they and their neighbors could get the health care and peace of mind that they deserve. That's what the Affordable Care Act is all about. The efforts from mayors, local officials, assisters and residents remind me of what's best in America, and what I see whenever I travel around the country: good people in strong communities who look out for each other and take care of their own. As always, Washington can learn a lot from the communities we represent."

The White House announced the "Healthy Communities Challenge" to engage key communities with large numbers or high percentages of uninsured in states across the country. Based on particularly high opportunity for impact with strong federal, state and community collaboration, the White House reached out to local officials in each of these 20 communities to get their uninsured constituents covered.

The lessons learned from every participating community will be invaluable in guiding enrollment efforts nationwide for years to come. Communities participating in the Healthy Communities Challenge utilized effective practices to increase enrollment during the open enrollment period. Below are just a few of the innovative tactics that participating communities used and that leaders across the country can adopt for future enrollment periods to make sure their constituents get covered.

Here are a few examples of tactics from Healthy Communities Challenge Cities:

- Mayor Kasim Reed in Atlanta attended open enrollment events to remind people of enrollment locations and to share information on benefits of the Affordable Care Act.
- In Chicago, Mayor Rahm Emanuel directed the City's 311 non-emergency services line to inform all callers of their ACA insurance options and provided guidance to operators to connect callers to enrollment opportunities.
- Dallas County Judge Clay Jenkins worked with the Dallas County Community College District to remind students to enroll on campus during National Youth Enrollment Day.
- Mayor Sly James in Kansas City created Public Service Announcements that were aired over 330 times on radio stations.
- In California, Mayor Robert Garcia of Long Beach recruited community organizations to undertake large canvassing efforts in areas with high-uninsured, subsidy-eligible populations
- In Milwaukee, Mayor Tom Barrett opened libraries for enrollment events, delivered thousands of flyers to promote enrollment events, and participated in robocalls and phone banking. County Executive Chris Abele ran digital signage on County buses, directing people to HealthCare.gov and additional services available through 211 to help individuals with the application process.
- Nashville Mayor Megan Barry released information about open enrollment during key festivities such as the Music City Bowl and the New Years' Eve festival, where about 250,000 people were in attendance.
- Mayor Mitch Landrieu in New Orleans created a challenge with barbershops and beauty salons to spread the word about open enrollment.
- Oakland Mayor Libby Schaaf set up a storefront for enrollment at City Hall for consumers to find information and enrollment assistance.
- In Philadelphia, Mayor Jim Kenney participated in a telethon for Latino radio stations and sent an email to the public school system's parent portal about enrollment.
- Mayor Ben McAdams in Salt Lake County focused on connecting navigators with a population of formerly incarcerated individuals and also with members of the refugee community.
- In Seattle and King County, "Health-Care Happy Hours" were held at social events that focused on small businesses and arts/culture.
- Tampa Mayor Bob Buckhorn's team distributed tens of thousands of fans throughout community centers, churches and libraries. The fans listed enrollment sites and provided Covering Tampa Bay's 1-800-number to set up appointments to enroll.

Final Results for the Healthy Communities Challenge

Success in the Healthy Communities Challenge was measured by the ratio, for each community, of the number of Marketplace plan selections by new consumers during open enrollment compared to the number of uninsured individuals eligible for Marketplace coverage at the beginning of open enrollment. Communities were defined as designated market areas (DMAs). New plan selections were reported by HHS or, where applicable, the State-Based Marketplace serving each community. The number of Marketplace-eligible uninsured was estimated by HHS.

DMA Name	New Marketplace Plan Selections During Open Enrollment	Marketplace-Eligible Uninsured at the Start of Open Enrollment	Ratio of New Plan Selections to Eligible Uninsured
MILWAUKEE	38,376	51,000	0.752
CHICAGO	130,852	178,000	0.735
ATLANTA	200,960	304,000	0.661
DETROIT	62,399	95,000	0.657
OAKLAND	83,723	134,000	0.625
PHILADELPHIA	102,712	178,000	0.577
SALT LAKE CITY*	74,259	135,000	0.550
CHARLOTTE	83,352	153,000	0.545

NASHVILLE*	49,281	98,000	0.503
SEATTLE	45,261	91,000	0.497
TAMPA	113,821	231,000	0.493
RICHMOND	28,912	59,000	0.490
LONG BEACH	217,347	480,000	0.453
KANSAS CITY	47,957	112,000	0.428
NEW ORLEANS	40,535	98,000	0.414
DALLAS-FT. WORTH	176,747	446,000	0.396
PHOENIX	66,999	194,000	0.345
LAS VEGAS	30,826	96,000	0.321
DENVER**	50,376	161,000	0.313
GREAT FALLS	2,970	13,000	0.228

* Some counties of this DMA are served by a State-Based Marketplace, not HealthCare.gov. The reported numbers of plan selections and QHP-eligible uninsured reflect only the portion of the DMA that is served by HealthCare.gov.

** Some counties of the Denver DMA are located outside Colorado and are served by HealthCare.gov, rather than Connect for Health Colorado. The reported numbers of plan selections and QHP-eligible uninsured reflect only the portion of the DMA in Colorado.

# # #

Marketplace Agent and Broker Toolkit

Resource that introduces important Marketplace and other health coverage topics, provides links to helpful resources on those topics, and contains information that help consumers apply for and enroll in Marketplace and other health coverage. Download.

Guidance on the SEP for Consumers without FFM Coverage due to Failure to File & Reconcile
Document with additional details on a time-limited special enrollment period (2/1/2016 through 3/31/2016) for individuals previously determined to be ineligible by the Marketplace to receive APTC in 2016 resulting from a failure to file and reconcile. Download.

###

Agents and Brokers: Updated Tax Materials Now Available

CMS has just released a number of tax-related resources at Marketplace.CMS.gov, which you can access by selecting the "Technical Resources" link. You can share these resources with consumers to help them understand the effect of having health coverage on their 2015 federal taxes.

CMS has provided two fact sheets on tax-related issues: "How Health Coverage Affects Your Taxes" and "No Health Coverage? What That Means for Your Taxes."

For additional resources that summarize the fact sheets content, you can also check out the drop-in articles "How Health Coverage Affects Your Taxes" and "No Health Coverage in 2015? What That Means for Your Taxes."

Remember: While you may provide information to consumers about the advance payments of the premium tax credit reconciliation process and the tax forms that they will receive from the Federally-facilitated Marketplace, it is important that you not provide any tax filing advice or answer any tax filing questions unless you are an authorized tax preparer.

Please refer consumers seeking answers to their questions or advice regarding their personal situations to a tax professional for assistance or to the tax assistance. For more information on the tax assistance options available, direct consumers to: IRS.gov/freefile or IRS.gov/VITA.

###

Agents and Brokers: New Marketplace Resources Available

The Centers for Medicare & Medicaid Services (CMS) has posted slides from the January 26 session of the "Open Enrollment: Operational Updates and Announcements for Agents and Brokers Participating in the Federally-facilitated Marketplaces (FFMs)" webinar series on the Agents and Brokers Resources webpage.

You can now find the full set of slides from the Open Enrollment weekly webinar series on the webpage. These webinars include information for you on how to help consumers select, enroll in, and use their Marketplace coverage, such as the HealthCare.gov look-up features and how to prepare for tax season.

Looking for additional Marketplace resources? Check out the new Agent and Broker Roadmap to Resources, a quick guide to resources for CMS and our federal partners that we have developed to help you navigate the FFMs and other health coverage topics.

###

Agent and Broker Roadmap to Resources

Now available now in the "Guidance" section of the Agents and Brokers Resources webpage.

The Roadmap is your quick guide to resources you may find helpful as you navigate the Health Insurance Marketplace and assist individuals and small businesses select, enroll in, and use coverage.

The Roadmap:

- Identifies and provides links to resources on important Marketplace health coverage topics, including where you can get direct help
- Explains coverage options available to consumers in the Marketplace
- Provides graphic summaries of many eligibility and enrollment processes
- Presents resources like checklists and troubleshooting tips to make it easier and faster for you to help consumers

###

Helpful Tax Readiness Resources

Consumers who enrolled in Federally-facilitated Marketplace (FFM) plans in plan year 2015 will receive forms that provide information about their health coverage for 2015. Some consumers may not know what to do with these forms and may contact you for guidance.

The Internal Revenue Service has prepared questions and answers about health care information forms to help consumers understand these forms, including who should expect to receive them and how to use the

information in them when preparing their federal income tax returns. The information on this webpage will be useful to you in helping consumers.

You can also direct consumers to resources CMS has provided on health coverage and federal income taxes at Marketplace.CMS.gov.

Remember: While you may provide information to consumers about the advance payments of the premium tax credit reconciliation process and the tax forms that they will receive from the FFM, it is important that you not provide any tax filing advice or answer any tax filing questions.

Please refer consumers seeking answers to their questions or advice regarding their personal situations to a tax professional for assistance. For more information on the tax assistance options available, direct consumers to: IRS.gov/freefile or IRS.gov/VITA.

###

Wondering how the Affordable Care Act will affect you?

This year almost all taxpayers must do something related to health care reporting requirements. The majority of taxpayers - more than three out of four - will simply need to check a box to verify they have health insurance coverage. For the minority of taxpayers who will have to do more, IRS.gov/aca features useful information and tips regarding the premium tax credit, the individual shared responsibility requirement and other tax features of the ACA. Publication 5201, The Health Care Law and Your Taxes, also provides a snapshot of ACA requirements.

###

Health Coverage Providers: Deadlines for Health Coverage Providers to Report Minimum Essential Coverage are Approaching

Who Must Report?

If you are a health insurance issuer, self-insured employer, or other entity that provided minimum essential coverage (MEC) during calendar year 2015, including a state government providing Medicaid or Children's Health Insurance Program (CHIP) coverage, you are subject to Affordable Care Act information reporting requirements.

What Must You Report?

You must report certain information to the IRS and to covered individuals about the coverage that you provided.

Which Forms Must You File?

Health insurance issuers, employers that are not applicable large employers and offer self-insured coverage, Medicaid and CHIP providers, and other MEC providers file Form 1094-B and Form 1095-B with the IRS and provide a copy of Form 1095-B to the covered individuals.

- Form 1095-B, *Health Coverage*: to report information to the IRS and to covered individuals about MEC
- Form 1094-B, *Transmittal of Health Coverage Information Returns*: to transmit your Forms 1095-B to the IRS and provide summary information about the individuals who are covered by MEC

Applicable large employers that sponsor self-insured group health plans should file Form 1094-C and Form 1095-C and report coverage information in Part III. A copy of the Form 1095-C should be provided to the employee.

- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*: to report information about coverage offered to full-time employees and MEC information about covered individuals

- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*: to transmit your Forms 1095-C to the IRS and provide summary information about the employer

When Are the Due Dates?

The due dates for the 2015 information reporting requirements have been extended as follows:

- Forms 1095-B and 1095-C: provided to individuals by Mar. 31, 2016

- Forms 1094-B and 1095-B and 1094-C and 1095-C: filed with the IRS by May 31, 2016, if filing on paper, or June 30, 2016, if filing electronically

More Information

For more information, see questions and answers about Information Reporting by Health Coverage Providers on IRS.gov/aca and the 2015 Instructions for Forms 1094-C and 1095-C.

###

Inflated Refund Claims Again Made the IRS "Dirty Dozen" List of Tax Scams for the 2016 Filing Season

The Internal Revenue Service warned taxpayers to be on the lookout for unscrupulous tax return preparers pushing inflated tax refund claims. This scam remains on the annual list of tax scams known as the "Dirty Dozen" for the 2016 filing season.

"Be wary of tax preparers that tout outlandish refunds based on federal benefits or tax credits you've never heard of or weren't eligible to claim in the past," said IRS Commissioner John Koskinen. "Taxpayers should choose preparers who file accurate returns."

Compiled annually, the "Dirty Dozen" lists a variety of common scams that taxpayers may encounter any time but many of these schemes peak during filing season as people prepare their returns or hire someone to help with their taxes.

Illegal scams can lead to significant penalties and interest and possible criminal prosecution. IRS Criminal Investigation works closely with the Department of Justice (DOJ) to shutdown scams and prosecute the criminals behind them.

Don't Fall Victim to Promises of Outlandish Refunds

Scam artists routinely pose as tax preparers during tax time, luring victims in by promising large federal tax refunds or refunds that people never dreamed they were due in the first place.

Scam artists use flyers, advertisements, phony store fronts and even word of mouth to throw out a wide net for victims. They may even spread the word through community groups or churches where trust is high. Scammers frequently prey on people who do not have a filing requirement, such as low-income individuals or the elderly. They also prey on non-English speakers, who may or may not have a filing requirement.

Scammers build false hope by duping people into making claims for fictitious rebates, benefits or tax credits. They charge good money for very bad advice. Or worse, they file a false return in a person's name and that person never knows that a refund was paid.

Scam artists also victimize people with a filing requirement and due a refund by promising inflated refunds based on fictitious Social Security benefits and false claims for education credits, the Earned Income Tax Credit (EITC), or the American Opportunity Tax Credit, among others.

The IRS sometimes hears about scams from victims complaining about losing their federal benefits, such as Social Security benefits, certain veteran's benefits or low-income housing benefits. The loss of benefits was the result of false claims being filed with the IRS that provided false income amounts.

While honest tax preparers provide their customers a copy of the tax return they've prepared, victims of scams frequently are not given a copy of what was filed. Victims also report that the fraudulent refund is deposited into the scammer's bank account. The scammers deduct a large "fee" before paying victims, a practice not used by legitimate tax preparers.

The IRS reminds all taxpayers that they are legally responsible for what's on their returns even if it was prepared by someone else. Taxpayers who buy into such schemes can end up being penalized for filing false claims or receiving fraudulent refunds.

Taxpayers can help protect themselves by doing a little homework before picking preparers who make refund claims that may sound too good to be true.

Start with the IRS Directory of Federal Tax Return Preparers with Credentials and Select Qualifications. This tool can help taxpayers find a tax return preparer with the right qualifications. The Directory is a searchable and sortable listing of certain preparers registered with the IRS. It includes the name, city, state and zip code of:

- Attorneys
- CPAs
- Enrolled Agents
- Enrolled Retirement Plan Agents
- Enrolled Actuaries
- Annual Filing Season Program participants

Also check the preparer's history. Ask the Better Business Bureau about the preparer. Check for disciplinary actions and the license status for credentialed preparers. For CPAs, check with the State Board of Accountancy. For attorneys, check with the State Bar Association. For Enrolled Agents, go to IRS.gov and search for "verify enrolled agent status" or check the Directory.

To find other tips about choosing a preparer, better understand the differences in credentials and qualifications, research the IRS preparer directory, and learn how to submit a complaint regarding a tax return preparer, visit www.irs.gov/chooseataxpro.

###

Guidance on the Special Enrollment Period for Consumers without Marketplace Coverage due to Failure to File and Reconcile

The Centers for Medicare & Medicaid Services (CMS) is providing a special enrollment period (SEP) for consumers who:

- are not currently enrolled in 2016 coverage through the Federally-facilitated Marketplace (FFM),
- are not receiving advance payments of the premium tax credit (APTC) in 2016 because they failed to file a tax return for 2014 and reconcile their APTC, and
- subsequently filed their 2014 tax return and reconciled their 2014 APTC.

This SEP will only be available to consumers after they restore their eligibility for APTC by filing a 2014 tax return, reconciling APTC paid on their behalf in 2014, and returning to the Marketplace to attest to having filed and reconciled 2014 APTC.

For more information click here:
https://www.regtap.info/uploads/library/ENR_FTR_SEP_Guidance_020516_5CR_020516.pdf

###

2017 Annual Instructions Guide to Health Insurance Issuers in Alabama, Missouri, Oklahoma, Texas, and Wyoming

Today the Centers for Medicare & Medicaid Services (CMS) released Annual Instructions to the Issuers for Plan Year 2017 to provide issuers in the Direct Enforcement states 2016 form filing instructions and Heath Insurance Oversight System (HIOS) technical assistance. This guidance also provides issuers in states without an effective rate review program 2016 rate filing instructions for plan year 2017.

For information click here: https://www.cms.gov/CCIIO/Resources/Training-Resources/Downloads/2016-Form-and-Rate-Filing-Instructions-and-HIOS-Tech-Assist-for-2017.pdf

###

KEY FACTS: Determining Household Size for Medicaid and CHIP

- Download PDF
  View key facts

KEY FACTS: Determining Household Size for Premium Tax Credits

- Download PDF
  View key facts

UPDATED: Tax Preparer's Guide to the ACA

- Download PDF
  View guide

###

Affordable Care Act: Tax Facts for Individuals and Families

The Affordable Care Act includes the individual shared responsibility provision and the premium tax credit that may affect your tax return. This year marks the first time that certain taxpayers will receive new health-care related information forms that they can use to complete their tax return and then keep with their tax records.

Information Forms – Forms 1095-A, 1095-B and 1095-C

Depending upon your specific circumstances, the Health Insurance Marketplace, health coverage providers, and certain employers may provide information forms to you early in 2016. These forms can help you accurately report health coverage information for you, your spouse and any dependents when you file your 2015 individual income tax return in 2016. The Marketplace, health coverage providers, and employers will also file these forms with the IRS.

The information forms are:

- Form 1095-A, Health Insurance Marketplace Statement: The Health Insurance Marketplace sends this form to individuals who enrolled in coverage there, with information about the coverage, who was covered, and when. This is the second year in which the Marketplace is issuing Form 1095-A to enrollees.
- Form 1095-B, Health Coverage: Health insurance providers – for example, health insurance companies – send this new form to individuals they cover, with information about who was covered and when.
- Form 1095-C, Employer-Provided Health Insurance Offer and Coverage: Certain employers send this new form to certain employees, with information about what coverage the employer offered. Employers that offer health coverage referred to as "self-insured coverage" send this form to individuals they cover, with information about who was covered and when.

The list below highlights key elements regarding these information forms:

- The deadline for the Marketplace to provide Form 1095-A is February 1, 2016.
- The deadline for coverage providers to provide Forms 1095-B and employers to provide Form 1095-C is March 31, 2016.
- If you are expecting to receive a Form 1095-A, you should wait to file your 2015 income tax return until you receive that form.
- Some taxpayers may not receive a Form 1095-B or Form 1095-C by the time they are ready to file their 2015 tax return. It is not necessary to wait for Forms 1095-B or 1095-C in order to file. Taxpayers may instead rely on other information about their health coverage and employer offer to prepare their returns
- These new forms should not be attached to your income tax return.

See our questions and answers that explain who should expect to receive the forms, how they can be used, and how to file with or without the forms, and that address various other questions you may have about these new forms.

Individual Shared Responsibility Provision

The individual shared responsibility provision requires everyone on your tax return to have qualifying health care coverage for each month of the year or have a coverage exemption. Otherwise, you may be required to make an individual shared responsibility payment.

The list below highlights key elements of the individual shared responsibility provision:

- If you maintain qualifying health care coverage for the entire year, you don't need to do anything more than report that coverage on your federal income tax return by simply checking a box. Qualifying coverage includes most employer-sponsored coverage, coverage obtained through a Health Insurance Marketplace, coverage through most government-sponsored programs, as well as certain other specified health plans.
- If you go without coverage or experience a gap in coverage, you may qualify for an exemption from the requirement to have coverage. If you qualify for an exemption, you use Form 8965, *Health Coverage Exemptions*, to report a coverage exemption granted by the Marketplace or to claim a coverage exemption on your tax return.
- If for any month during the year you don't have qualifying coverage and you don't qualify for an exemption, you will have to make an individual shared responsibility payment when you file your federal income tax return.
- The payment amount for 2015 is the greater of 2 percent of the household income above the taxpayer's filing threshold, or $325 per adult plus $162.50 per child (limited to a family maximum of

$975). This payment is capped at the cost of the national average premium for a bronze level health plan available through Marketplaces that would provide coverage for the taxpayer's family members that neither had qualifying coverage nor qualify for a coverage exemption. The instructions for Form 8965, *Health Coverage Exemptions*, provide the information needed to calculate the payment that will be reported on you federal income tax return.

- Form 1095-B will be sent to individuals who had health coverage for themselves or their family members that is not reported on Form 1095-A or Form 1095-C. Form 1095-A will be sent to individuals who enrolled in health coverage for themselves or their family members through the Marketplace. Form 1095-C will be sent to certain employees of applicable large employers.
- Some taxpayers may not receive a Form 1095-B or Form 1095-C by the time they are ready to file their 2015 tax return. It is not necessary to wait for Forms 1095-B or 1095-C in order to file. Taxpayers may instead rely on other information about their health coverage and employer offer to prepare their returns

Health Coverage Exemptions

Individuals who go without coverage or experience a gap in coverage may qualify for an exemption from the requirement to have coverage.

- You may qualify for an exemption if one of the following applies:
  - You do not have access to affordable coverage
  - You have a one-time gap of less than three consecutive months without coverage
  - You qualify for one of several other exemptions, including a hardship exemption
- How you get an exemption depends upon the type of exemption. You can obtain some exemptions only from the Marketplace in the area where you live, others only from the IRS when filing your income tax return, and others from either the Marketplace or the IRS. For more information, visit IRS.gov/aca or see the instructions to Form 8965.
- If you qualify for an exemption, you use Form 8965 to report a coverage exemption granted by the Marketplace or to claim a coverage exemption on your tax return.

Premium Tax Credit

For an explanation of the Premium Tax Credit see IRS Fact Sheet 2016-05, entitled "Tax Credit Helps Make Health Insurance Affordable for Middle-Class Americans."

More Information

Remember that filing electronically with tax preparation software is the quickest and easiest way to file a complete and accurate tax return, as the software guides you through the filing process and does all the math for you.

For more information about the premium tax credit or the individual shared responsibility payment, visit IRS.gov/aca. For more information about the Marketplace, visit HealthCare.gov. For more information on the new health care related information forms, see the Form 1095 questions and answers.

SMD Letter on Implementation of Covered Outpatient Drug Final Rule Provisions Regarding Reimbursement for Covered Outpatient Drugs in the Medicaid Program

Today the Centers for Medicare & Medicaid Services (CMS) issued a letter to a State Medicaid Directors providing guidance to the states concerning implementation of the Covered Outpatient Drug final rule with comment (CMS-2345-FC) (81 FR 5170) published on February 1, 2016, concerning final regulations

pertaining to reimbursement for covered outpatient drugs in the Medicaid program. It outlines the key changes that states need to address when determining their reimbursement methodologies, including the revised requirement in 42 CFR §447.512(b) for states to reimburse at an aggregate upper limit based on actual acquisition cost (AAC) plus a professional dispensing fee established by the agency; the implementation of the Affordable Care Act federal upper limit (FUL); and requirements for the 340B entities, 340B contract pharmacies, Indian Health Service (IHS), Tribal, and Urban Indian Organization (I/T/U) pharmacies.

For more information on the letter click here: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16001.pdf or

https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html

Medicare and Medicaid Updates

CMS Extends the Attestation Deadline for the EHR Incentive Programs to March 11, 2016

The Centers for Medicare & Medicaid Services (CMS) extended the attestation deadline for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs to **Friday, March 11, 2016 at 11:59 p.m. ET,** from the original deadline of Monday, February 29.

Eligible professionals, eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program can attest through the CMS Registration and Attestation System. Providers participating in the Medicaid EHR Incentive Program should refer to their respective states for attestation information and deadlines. Certain Medicaid eligible professionals may use the Registration and Attestation System as an alternate attestation method to avoid the Medicare payment adjustment (80 FR 62900 through 62901).

To attest to the EHR Incentive Programs in 2015:

- **Eligible Professionals** may select an EHR reporting period of any continuous 90 days from January 1, 2015 (the start of the 2015 calendar year) through December 31, 2015.
- **Eligible Hospitals/CAHs** may select an EHR reporting period of any continuous 90 days from October 1, 2014 (the start of the federal fiscal year) through December 31, 2015.

Attestation Resources

For assistance with attestation, please review the following CMS resources:

- Preparing to Participate in the EHR Incentive Programs Fact Sheet
- Attestation Worksheet and User Guide for Eligible Professionals
- Attestation Worksheet and User Guide for Eligible Hospitals and CAHs
- Broadband Access Exclusions Tip Sheet
- Health Information Exchange Fact Sheet
- Public Health Reporting in 2015 for Eligible Professionals

- Public Health Reporting in 2015 for Eligible Hospitals/CAHs

For More Information

Visit the Registration and Attestation the 2015 Program Requirements pages on the CMS EHR Incentive Programs website. For attestation questions, please contact the EHR Information Center Help Desk at (888) 734-6433/ TTY: (888) 734-6563. The hours of operation are Monday to Friday between 7:30 a.m. and 6:30 p.m. EST.

###

Making Preferred Cost Sharing Pharmacies More Available

The benefits Medicare provides are only as good as the access beneficiaries have to them. That's why beneficiary access is a founding principle of our work at CMS.

Last year, we heard concerns that some beneficiaries did not have ready geographic access to preferred cost-sharing pharmacies. Increasingly, Part D plans are creating smaller networks of pharmacies within their larger networks and offering lower cost-sharing arrangements to beneficiaries who use these preferred cost-sharing pharmacies. Plans market these lower cost-sharing arrangements, which are appealing to beneficiaries looking to save money on their prescription drugs. However, in some instances, these pharmacies were not geographically accessible to the beneficiaries in the plan.

In our analysis of Part D beneficiary access to preferred cost-sharing pharmacies (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/PCSP-Key-Results-Report-Final-v04302015.pdf), which was released in April 2015, we analyzed the availability of these pharmacies to Part D enrollees. We were pleased to learn that most Part D enrollees live in areas where Part D plans provide reasonably robust preferred cost-sharing pharmacy networks. However, some beneficiaries in all areas, but particularly those in urban areas, face limited, or in some instances, no geographic access to preferred cost-sharing pharmacies.

We took action. In last year's (2016) Medicare Advantage Rate Notice and Part D Call Letter (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf), we announced that we would: 1) work with outlier plans to address our concerns about access and marketing; 2) require plans whose preferred cost-sharing networks are outliers (i.e., they offer significantly less access to preferred cost-sharing pharmacies) in 2016 to disclose in marketing materials that their plan offers less access; and 3) publish access levels for each plan offering a preferred cost sharing benefit structure.

Plans responded. We are pleased to share that, based on data we are posting on cms.gov today (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html), access to preferred cost-sharing pharmacies has improved. The bottom 10th percentile of plans in 2016 offer access within two miles to 71% of urban beneficiaries, as compared to 40% of beneficiaries in 2014. This is just one example of ways CMS and Part D sponsors are working together to improve Medicare beneficiaries' access to benefits.

###

CMS proposes 2017 payment and policy updates for Medicare Health and Drug Plans

Proposed policies maintain stability of Medicare Advantage program

The Centers for Medicare & Medicaid Services (CMS) today released proposed changes for the Medicare Advantage and Part D Prescription Drug Programs in 2017 that will, if finalized, provide stable and fair payments to plans, and makes unprecedented improvements to the program for plans that provide high quality care to the most vulnerable enrollees.

"These proposals continue to keep Medicare Advantage strong and stable and as with this past year, support the provision of high quality, affordable care to seniors and people living with disabilities," said CMS Acting Administrator Andy Slavitt. "In particular, these proposals support investment in dually Medicare-Medicaid eligible individuals and those with complex socioeconomic needs."

The net payment impact of the proposed updates would result in a modest increase of 1.35 percent on average for Medicare Advantage plans, although individual plans' experiences will vary. This moderate growth is consistent with last year's update and reflects a similar pattern in Medicare fee-for-service. Plans that improve the quality of care they deliver to enrollees can see higher updates and can grow and enhance the benefits they offer to enrollees.

CMS is also proposing to improve the precision of payments to Medicare Advantage plans that serve vulnerable populations such as dually eligible or low income beneficiaries. CMS proposes to adjust Star Ratings to reflect the socioeconomic and disability status of a plan's enrollees. In addition, CMS proposes to revise the methodology used to risk adjust payments to plans to more accurately reflect the cost of care for dually eligible beneficiaries.

Enrollment and quality have grown in Medicare Advantage and Part D since enactment of the Affordable Care Act:

- Medicare Advantage has reached record high enrollment each year since 2010, a trend continuing in 2016 with a cumulative increase of 50 percent to an all-time high of more than 17.1 million beneficiaries.
- Nearly 32 percent of Medicare beneficiaries are enrolled in a Medicare Advantage plan.
- Average Medicare Advantage premiums have fallen by nearly 10 percent from 2010 to 2016.
- The percentage of Medicare Advantage enrollees in four or five star contracts has almost quadrupled since 2009 to 71 percent.
- About one-third of prescription drug plan enrollees are in Part D plans with four or more stars, compared to 27 percent of enrollees in such plans in 2009.

The average number of Medicare plan choices remains consistent in 2016 as compared to 2015, and access to supplemental benefits, such as dental and vision benefits, is growing. The proposed policies in the Advance Notice and Draft Call Letter continue to strengthen and improve the Medicare Advantage program for current and future generations, including the program's ability to serve Medicare beneficiaries with diverse needs.

###

Advance Notice and Draft Call Letter

For a general fact sheet on the 2017 Advance Notice and Draft Call Letter, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-19.html.

For more information on Puerto Rico and the 2017 Advance Notice and Draft Call Letter, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-19-1.html. For more information on steps the Department of Health and Human Services have taken to help ensure that residents of Puerto Rico continue to have access to quality and affordable health care and a more sustainable future, please visit: http://www.hhs.gov/about/news/2016/02/18/hhs-fact-sheet-working-solve-health-care-challenges-puerto-rico.html.

The 2017 Advance Notice and Draft Call Letter may viewed through: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html and selecting "2017 Advance Notice." Comments on the proposed Advance Notice and Draft Call Letter are invited from industry, seniors, consumer advocates, and the public and must be submitted by March 4, 2016. The 2017 Final Rate Announcement and Call Letter will be published on Monday, April 4, 2016.

###

Medicare Reporting and Returning of Self-Identified Overpayments - CMS 6037-F Final Rule

The Centers for Medicare & Medicaid Services (CMS) has published a final rule that requires Medicare Parts A and B health care providers and suppliers to report and return overpayments by the later of the date that is 60 days after the date an overpayment was identified, or the due date of any corresponding cost report, if applicable. A separate final rule was published in the May 23, 2014 **Federal Register** (79 FR 29844) that addresses Medicare Parts C and D overpayments.

Summary

The requirements in this rule are meant to support compliance with applicable statutes, promote the furnishing of high quality care, and to protect the Medicare Trust Funds against improper payments, including fraudulent payment. This rule clarifies requirements for the reporting and returning of self-identified overpayments. Health care providers and suppliers have been and will remain subject to the statutory requirements found in section 1128J(d) of the Social Security Act (the Act) and could face potential False Claims Act (FCA) liability, Civil Monetary Penalties Law (CMPL) liability, and exclusion from federal health care programs for failure to report and return an overpayment. Health care providers and suppliers will also continue to be required to comply with current CMS procedures when we, or our contractors, determine an overpayment exists and issue a demand letter.

Background

Section 6402(a) of the Affordable Care Act established a new section 1128J(d) of the Act. Section 1128J (d) (1) of the Act requires a person who has received an overpayment to report and return the overpayment to the Secretary, the state, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and to notify the Secretary, state, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment. Section 1128J(d)(2) of the Act

requires that an overpayment be reported and returned by the later of: (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable. Section 1128J (d) (3) of the Act specifies that any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation (as defined in 31 U.S.C. 3729(b) (3)) for purposes of 31 U.S.C. 3729. In the February 16, 2012 Federal Register (77 FR 9179),

CMS published a proposed rule to implement the provisions of section 1128J (d) of the Act for Medicare Parts A and B providers and suppliers.

Major Provisions

The major provisions of this final rule include clarifications around: the meaning of overpayment identification; the required look back period for overpayment identification; and the methods available for reporting and returning identified overpayments to CMS.

Meaning of "Identification"

Section 1128J(d) of the Act provides that an overpayment must be reported and returned by the later of: (i) the date which is 60 days after the date on which the overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. This final rule states that a person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. Creating this standard for identification provides needed clarity and consistency for health care providers and suppliers regarding the actions they need to take to comply with requirements for reporting and returning of self-identified overpayments.

Look back Period

Under this final rule, overpayments must be reported and returned only if a person identifies the overpayment within six years of the date the overpayment was received. Specifying the length and other parameters of the look back period provides additional clarity for providers and suppliers who have identified an overpayment that is covered by the provisions of 1128J(d).

How to Report and Return Overpayments

This final rule provides that providers and suppliers must use an applicable claims adjustment, credit balance, self-reported refund, or another appropriate process to satisfy the obligation to report and return overpayments. This approach for returning overpayments provides an array of familiar options from which providers and suppliers can select.

This rule also provides that if a health care provider or supplier has reported a self-identified overpayment to either the Self-Referral Disclosure Protocol managed by CMS or the Self-Disclosure Protocol managed by the Office of the Inspector General (OIG), the provider or supplier is considered to be in compliance with the provisions of this rule as long as they are actively engaged in the respective protocol.

CMS Fact Sheet (PDF & WORD) - or click here:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-11.html

Helpful Weblinks:

Reporting and Returning of Overpayments (CMS-6037-F) (PDF) https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-02789.pdf and on 02/12/2016 and available online at http://federalregister.gov/a/2016-02789

###

Visit the CMS Website for Additional Guidance on Submitting a Hardship Exception Application for the 2015 EHR Reporting Period

The Centers for Medicare & Medicaid Services (CMS) has released a new frequently asked question (FAQ) that indicates providers who submit a hardship exception application may still attest to the Medicare Electronic Health Record (EHR) Incentive Program for the 2015 EHR Reporting Period.

FAQ #14357 - If I submit a hardship exception application by the March 15, 2016 deadline, does that mean that I cannot attest for the 2015 EHR reporting period and possibly receive an incentive payment?

No. Submission of a hardship exception application does not prevent providers from attesting and receiving an incentive payment if meaningful use requirements are met.

Attestation for the 2015 EHR reporting period is currently open. We urge providers to try to attest by the March 11, 2016 attestation deadline. If they attest successfully, they will avoid the payment adjustment in 2017 and may also be eligible to receive an EHR incentive payment.

However, if providers cannot attest for a 2015 reporting period— or if they believe their attestation may be unsuccessful—then they may apply for a hardship exception to avoid the payment adjustment in 2017. The application will not prevent providers from earning an incentive if their attestation is successful. The deadline to submit a hardship exception application is **March 15, 2016 for eligible professionals** and **April 1, 2016 for eligible hospitals**.

###

View Updated FAQs on the CMS Website

The Centers for Medicare & Medicaid Services (CMS) has recently updated two FAQs that provide information on: 1) hospital-based eligible professionals' eligibility to receive incentive payments from the Medicare and Medicaid EHR Incentive Programs, and 2) eligible hospitals' requirements for meeting the specialized registry objective. Please review the updated information below.

FAQ #2639 - **Are physicians who practice in hospital-based ambulatory clinics eligible to receive Medicare or Medicaid electronic health record (EHR) incentive payments?**

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90 percent or more of his/her services in either the inpatient or emergency department of a hospital. Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.

If you are a new EP and need to determine your hospital-based status, contact the EHR information center at (888)734-6433 and choose option 4 in the interactive voice response system (IVR). You will need your National Provider Identifier (NPI) and the last 5 digits of your Tax Identification Number (TIN). If you are an existing EP, review and resubmit your registration on the Registration & Attestation website to determine your hospital based status.

FAQ #14117 - What steps do eligible hospitals need to take to meet the specialized registry objective? Is it different from EPs?

For an eligible hospital, the process is the same as for an EP. However, we note that eligible hospitals do not need to explore every specialty society with which their hospital-based specialists may be affiliated. The hospital may simply check with the jurisdiction and any such organization with which it is an affiliate, if no such organization exists, and if their jurisdiction has no registry, they may simply exclude from the measure.

###

Road to Recovery

Get up-to-date on the current state of Medicare Part C and Part D fraud, waste and abuse (FWA) in minutes by viewing a new infographic – The Road to Recovery.

This infographic offers an at-a-glance view of the financial impact of FWA on Parts C and D as well as the return on investment for program integrity efforts. You can also see which schemes continue to affect Medicare Parts C and D, which states are a hotbed for fraud and how your anti-fraud efforts have led to success.

###

Please See Updated Phone Instructions for Eligible Professionals in FAQ #2639

The Centers for Medicare & Medicaid Services (CMS) has recently updated two FAQs that provide information on: 1) hospital-based eligible professionals' eligibility to receive incentive payments from the Medicare and Medicaid EHR Incentive Programs, and 2) eligible hospitals' requirements for meeting the specialized registry objective. Please review the updated information below.

Note: FAQ #2639 includes new instructions for EPs—that are highlighted in bold text below—who would like to contact the EHR information center about their hospital-based status.

FAQ #2639 - Are physicians who practice in hospital-based ambulatory clinics eligible to receive Medicare or Medicaid electronic health record (EHR) incentive payments?

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90 percent or more of his/her services in either the inpatient or emergency department of a hospital. Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.

If you are a new EP and need to determine your hospital-based status, contact the EHR information center at (888) 734-6433. **Choose option 1 for the EHR Incentive Programs, then choose option 4 in the interactive voice response system (IVR).** You will need your National Provider Identifier (NPI) and the last 5 digits of your Tax Identification Number (TIN). If you are an existing EP, review and resubmit your registration on the Registration & Attestation website to determine your hospital-based status.

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hospital may simply check with the jurisdiction and any such organization with which it is an affiliate, if no such organization exists, and if their jurisdiction has no registry, they may simply exclude from the measure.

###

CMS publishes Medicare Fee-for-Service Provider & Supplier Lists

Posting of ambulance, home health utilization data follows recent provider and supplier moratoria extension

As part of our efforts to improve care delivery, data sharing, and transparency, the Centers for Medicare & Medicaid Services (CMS) is releasing two public data sets regarding the availability and use of services provided to Medicare beneficiaries by ground ambulance suppliers and home health agencies, as well as a list of Medicare fee-for-service (FFS) providers and suppliers currently approved to bill Medicare. The data sets are accessible at https://data.cms.gov.

CMS recently published a Federal Register notice on February 2, 2016 (effective January 29, 2016) extending the temporary enrollment moratoria on new ground ambulance suppliers and home health agencies sub-units, and branch locations in the Medicare, Medicaid, and the Children's Health Insurance Programs (CHIP) for an additional six months in seven geographic areas. Such moratoria provisions were authorized by the Affordable Care Act and serve to reduce fraud, waste, and abuse while ensuring that patient access to care is not interrupted.

The enrollment moratoria extension, coupled with these new provider and supplier data tools, signal that the potential for fraud, waste, and abuse that continues to exist in these areas. "CMS has used this powerful monitoring tool several times before to fight fraud, safeguard taxpayer dollars, and protect beneficiaries. By introducing data mapping for these specific, high-risk providers and suppliers in the moratoria areas and, for the first time, making service area data on all other FFS providers and suppliers publicly available, analyses of the data offers additional insight for CMS and its stakeholders," said CMS Deputy Administrator and Center for Program Integrity Director Shantanu Agrawal, M.D. "Use of these tools gives us evidence of the use, disproportion, and saturation of certain services within Medicare, Medicaid, and CHIP coverage and provides insight beneficial to reducing program threats, assisting law enforcement, and averting harm to patients and the public."

Future data releases may include comparable information on additional health services outside the seven moratoria areas.

The Moratoria Provider Services and Utilization Data Tool includes interactive maps and a dataset that shows national-, state-, and county-level provider and supplier services and utilization data that can be used by CMS to determine which geographic and health service areas might be considered for a moratorium on new provider and supplier enrollments. The data provides the number of Medicare providers and suppliers servicing a geographic region, identifies moratoria regions at the state and county levels, and identifies the number of people with Medicare benefits who use a specific health service in that region. The data can also be used to reveal service levels related to the number of providers and suppliers in a geographic region. Utilization data and geographic regions for these services can be easily compared using interactive maps.

CMS' ongoing program integrity work has inspired growing stakeholder interest in Medicare provider and supplier enrollment information, Agrawal said. The Public Provider data allow users, including other health plans, to easily access and validate provider and supplier information against Medicare data. Public

Provider Enrollment file sets include information on providers and suppliers, nationwide, who are approved to bill Medicare. The data is extracted directly from the Provider Enrollment, Chain and Ownership System (PECOS) and is updated quarterly.

The Moratoria Provider Services and Utilization Data Tool was created using ground ambulance and home health agency paid claims data that reside in CMS systems for Medicare FFS beneficiaries. The data in this release cover the period from October 1, 2014 to September 30, 2015 and will continue to be updated quarterly. Data are available for each of the 50 states, their counties, and the District of Columbia. The data set does not contain any individually identifiable information about Medicare beneficiaries.

The public provider data consist of individual and organizational provider and supplier enrollment information and includes names, National Provider Identifier and other unique identifiers, enrollment type, specialty, and limited address information (City, State, and ZIP Code).

For more information on the recent temporary enrollment moratoria extension please see the Federal Register posting at: http://federalregister.gov/a/2016-01835. To view the Ambulance and Home Health Agency data set and a related fact sheet, visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-22.html. To view the Public Provider Enrollment data set and a related fact sheet, visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-22-2.html.

###

Compassionate Allowances Speed Help to People with Severe Disabilities

Disability can happen to anyone. If you suffer from a serious medical condition that prevents you from working, time is of the essence when it comes to applying for Social Security disability benefits. Although Social Security is committed to processing … Continue reading →

###

Medicare Scam

Did you know that fraudsters are offering "free" genetic testing to gain access to Medicare enrollees' personal or Medicare information? Scammers are approaching unsuspecting enrollees at local health fairs, senior housing facilities, community centers, home health agencies and other trustworthy locations to carry out this scam.

The Centers for Medicare & Medicaid Services' (CMS) Center for Program Integrity (CPI) has developed a new mail insert you can use to alert enrollees about this scam and how they can protect themselves from fraud. CPI encourages plan sponsors to customize inserts with their customer service number and print inserts to include in plan statements or other materials sent to enrollees.

This and other Fraud Awareness Inserts are available to download from the CMS O&E MEDIC website.

###

Federal Poverty Guidelines

The 2016 Federal Poverty guidelines have been announced. You can find details on this in a couple different places:

- The Federal Register Notice: https://www.gpo.gov/fdsys/pkg/FR-2015-01-22/pdf/2015-01120.pdf
- HHS: https://aspe.hhs.gov/poverty-guidelines
- NCOA has some good detailed information and charts on their website: https://www.ncoa.org/news/ncoa-news/center-for-benefits-news/updated-benefits-eligibility-2016/?utm_source=email&utm_medium=newsletter&utm_content=income_charts_2016&utm_campaign=BenefitsAlerts&utm_term=2016_02_17

###

CMS Plans to Correct Attestation System to Allow EPs to Claim an Exclusion for Measure 1 of the Patient Electronic Access Objective

The Centers for Medicare & Medicaid Services (CMS) will shut down the Medicare & Medicaid EHR Incentive Program Registration and Attestation System on Sunday, **February 21, 2016, between 6:00 a.m. and 10:00 a.m. EST**, to correct an error that is preventing eligible professionals (EPs) from claiming an exclusion for Measure 1 of the Patient Electronic Access Objective (referred to as 8A in the attestation system).

Patient Electronic Access, Measure 1 Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for 'Patient Name' and 'Provider's name and office contact information.'

EPs whose attestation was rejected as a result of not meeting objective 8 may modify and resubmit their attestation information after February 21, 2016. EPs who have successfully attested to the EHR Incentive Programs' 2015 requirements do not need to take any action.

Batch attestation users who have not yet submitted their files will also need to wait to submit their data until after February 21. To successfully upload a batch attestation with this exclusion, please ensure the batch files include a 'Y/N' indicator for each provider record on the file. Users who have already submitted a batch attestation file for the 2015 program year do not need to resubmit.

Upcoming Webinars and Events

Accountable Health Communities (AHC) Model

Dear Regional Partners

On Tuesday, March 1st, at 1:00 pm, the Kansas City Regional Office will be holding a stakeholder call to discuss the recently announced Accountable Health Communities (AHC) Model. The AHC Model is intended to address the critical gap between clinical care and community services in the current healthcare delivery system. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce individuals' ability to

manage these conditions, increase health care costs, and lead to avoidable health care utilization. The AHC model will test whether increased awareness of, and access to, services addressing health-related social needs will impact total health care costs and improve the health and quality of care for Medicare and Medicaid beneficiaries in targeted communities.

CMS will support up to 44 cooperative agreements as part of this model, with awards ranging from up to $1 million in Track 1 of the model, to up to $4.51 million in Track 3.

Eligible applicants are community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network with clinical delivery sites and community service providers. Applicants from all 50 states, U.S. Territories, and the District of Columbia may apply.

Attached, please find a Fact Sheet on the AHC Model. These calls will be for discussion only. As this is an open funding opportunity, we will not be able to answer questions directly over the phone. All questions, however, will be collected and sent to subject matter experts for response. For specific questions not answered in the Fact Sheet or the Funding Opportunity Announcement, you may also send an email to AccountableHealthCommunities@cms.hhs.gov.

What: **CMS Region 7 Call on Accountable Health Communities**

When: **Tuesday, March 1, 2016 @ 1:00 pm Central Time**

Call-in #: **1-877-267-1577 / Meeting Number: 999 517 656**

URL: https://meetings.cms.gov/orion/joinmeeting.do?MeetingKey=999517656

RSVP Is Not Required

We look forward to speaking with you. If you have any questions, please contact Nancy Rios at Nancy.Rios@cms.hhs.gov.

Nanette Foster Reilly, Consortium Administrator

Consortium for Financial Management and Fee for Service Operations

601 East 12th Street, Kansas City, MO 64106

###

Special Enrollment Periods - **Register now**
Thursday, March 3, 2016

1:00 pm – 2:30 pm CT
The webinar will discuss the circumstances that trigger a special enrollment period and will review the timing of coverage effective dates for different triggering events. It will also clarify changes and updates to the circumstances that trigger a special enrollment period.

Rural Health Clinic Webinar Series

The series begins on Friday, February 26th.

Topics include:

- RHC Regulatory Requirements: Are You Ready for Your Next Survey
- Understanding the Mechanics of Your Medicare Cost Report
- RHC Billing: Big Changes Coming in 2016

For more information contact Michelle Miner at (800) 280-0354 or mminer@eidebailly.com.

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If you wish to unsubscribe from future CMS Region 7 emailings, please send an email to Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov with the word "Unsubscribe" in the subject line.