

CMS Region 7 Updates

06/02/2016

ACA/Marketplace Updates

Notices Have Been Mailed to Consumers Who May Be Enrolled in Marketplace Coverage with APTC or CSRs and Medicaid or CHIP (Reminder)

Periodic Data Matching (PDM) is the process the Marketplace uses to identify consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers). This month, as part of PDM, the Marketplace mailed paper notices to the household contact for any consumers it found to be dually-enrolled. The notices tell consumers to either: immediately end their Marketplace coverage with APTC/CSRs if they are enrolled in Medicaid or CHIP, with instructions on how to do so; or to take no further action if they are no longer enrolled in Medicaid or CHIP.

Most Medicaid or CHIP is considered MEC. Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) and aren't considered MEC. (For more information on which Medicaid programs are considered MEC, click [here](#).)

Consumers in the following states will not receive notices in this round of PDM: GA, ME, NH, NJ, and WY.

Here are some resources that may be helpful in working with consumers:

- Guidance on [cancelling a Marketplace plan when you get Medicaid or CHIP](#)

[Clarification of Periodic Data Matching Notice versus Data Matching Issue Notice for Non-ESC MEC Medicaid/CHIP](#)

###

June is Lesbian, Gay, Bisexual, and Transgender (LGBT) Pride Month

This year's Pride season is particularly exciting as we celebrate the anniversary of marriage equality as well as unprecedented new nondiscrimination protections under the Affordable Care Act. Join us in using the 2016 Pride season to encourage LGBT communities to enroll in health coverage. Join us in using the 2016 Pride season to encourage our community to take #PrideInOurHealth and #BeOutBeHealthy by getting covered and taking advantage of everything that health insurance has to offer.

Out 2 Enroll Webinar

Please join us on **Friday, June 10 from 2:00 pm to 3:30 pm ET** for a special assister webinar in partnership with [Out2Enroll](#) on reaching and assisting lesbian, gay, bisexual, and transgender (LGBT) communities. Assister organizations that take the training webinar can get listed in Out2Enroll's [web](#)

[tool](#) that allows LGBT consumers to search for LGBT-friendly assisters in their area. You can contact Out2Enroll at info@out2enroll.org to learn more about the tool. [Click here to register for this presentation!](#)

Key messages for LGBT consumers:

- **Coverage 2 Care.** Throughout the summer, we will continue to encourage the LGBTQ community to take advantage of the benefits of health insurance, including finding an LGBTQ-friendly provider and accessing free preventive services covered under the Affordable Care Act.
- **Special Enrollment.** Many people are eligible for a special enrollment opportunity to #GetCovered outside of open enrollment season, but many consumers are unaware of this option. Qualifying events include getting married, having or adopting a child, moving to a new area, or losing your health insurance. As we celebrate the anniversary of marriage equality this June, it is a perfect opportunity to remind our community to take advantage of special enrollment opportunities.
- **Health Care Is a Right/Nondiscrimination.** There is much to celebrate following the release of the final rule on [Section 1557](#), and public education will be critical to ensuring that these new rules are fully enforced and available to all LGBTQ people. We'll be using Pride season to remind our friends and family that we cannot be discriminated against in health coverage or health care.

###

Help Graduates get Covered!

Young adults all over the country are graduating and entering the workforce this summer. In your outreach, education and enrollment efforts geared toward young adults and their families, let them know that if they don't have an offer of employer-sponsored coverage (ESC) that is [affordable](#) (according to the ACA definition) and meets [minimum value](#) (MV), they have 3 options to get covered. Remind these consumers that if they don't have any health coverage they may have to pay a penalty and there's no special exception for age or student status.

Under 26? Stay or get covered on a parent's health insurance plan

- You may be able to get added to or stay [covered under a parent's health insurance plan](#) until you turn 26 — even if you're married, not living at home, financially independent, or have an offer of insurance through a job.

Buy your own health insurance plan

- You may be able to buy your own plan through the Health Insurance Marketplace. If you're just starting out and not making much money, you'll probably qualify for [savings](#) — which may make your monthly health insurance bill less than your cell phone bill.
- You also can choose a ["Catastrophic" health plan](#) — an affordable way to protect yourself from worst-case scenarios.
- Outside the yearly [Open Enrollment Period](#), you can enroll only if you have a life change that qualifies you for a [Special Enrollment Period](#). Turning 26 and dropping off a parent's insurance plan, losing health insurance for any other reason, getting married, or having a baby are just a few changes that let you enroll in the off-season.
- [See if you qualify for a Special Enrollment Period.](#)

Get coverage through Medicaid or CHIP

- In some states, Medicaid [covers all adults below a certain income level](#). If you qualify, you can enroll any time. [See if this applies to your income and your state](#).
- In all states, [Medicaid and the Children's Health Insurance Program \(CHIP\)](#) provide health coverage for some individuals, families and children, pregnant women, and people with disabilities.

###

Don't Forget About Dental Coverage!

Access to dental care is an important aspect of maintaining good health, but it's something that's commonly overlooked when consumers look for health coverage. Remind consumers not to forget about getting dental coverage! Consumers can obtain dental coverage in the Health Insurance Marketplace in 2 ways; as part of a health plan, or by itself through a stand-alone dental plan:

- Some health plans include dental coverage and this information is available in the Marketplace. Consumers can view which plans offer dental coverage by comparing them. Consumers who select a health plan with dental coverage can expect to pay one monthly premium to cover the health and dental plan. This dental plan option can only be modified during Open Enrollment. Cancellation of the dental plan on Healthcare.gov will also cancel the health plan.
- Stand-alone dental plans are also offered in the Marketplace. This option is available to consumers who select a health coverage that does not include dental coverage or for consumers who want a different dental coverage. Consumers who select a stand-alone dental plan will pay a separate, additional premium. The stand-alone dental plan option can be cancelled at any time during the year by contacting the plan or the Marketplace call center.

For more information on dental coverage in the Marketplace click [here](#)

To preview health plans or stand-alone dental plans for 2016 click [here](#)

###

Marketplace Brand Guidelines (Revised)

CMS has updated and reposted the Health Insurance Marketplace: Brand Identity and Design Standards. Assisters should use the standards outlined in this guide as you develop materials to market your services or educate consumers about the Marketplace. The guidelines can be found on Marketplace.cms.gov.

Please be aware of revisions to the Health Insurance Marketplace logo in particular, which drop the "stylized H" blue and green graphic to the left of the words. The previous logo should no longer be used on public-facing communications. New logo files are available upon request to Logos@cms.hhs.gov

(This email address corrects the incorrect address from the April 18th newsletter).

Existing materials should be updated as soon as possible, but without incurring additional costs (i.e. concurrently with other routine updates or production).

###

Assister Resource

[Assister Guide to the Immigration Section of the Online Marketplace Application](#)

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Guidance on Annual Eligibility Redetermination and Re-enrollment for Marketplace Coverage for 2017

CMS has released guidance that outlines the alternative procedures for benefit year 2017 to annually redetermine eligibility for enrollment in a QHP through the Marketplace. Like the guidance for benefit year 2016, the procedures described in this year's guidance preserve a core feature of the annual redetermination process: namely, that most enrollees do not have to take action to retain their coverage for 2017, which is important in promoting continuity of coverage while limiting administrative burden for enrollees, issuers, and Marketplaces.

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ARR-2017-Guidance-051016-508.pdf>

###

Iowa Health Insurance Marketplace Premium Increases Were Not What They Seemed Last Year

A new [report](#) from the U.S. Department of Health and Human Services demonstrates that proposed premium changes from preliminary rate filings do not capture what Marketplace consumers actually pay. The report found that, last year, the average cost of Marketplace coverage for people getting tax credits went from \$102 to \$106 per month, a 4% change, despite [suggestions](#) of "double-digit price hikes."

The report debunks the myth—based on last year's rate filings—that consumers experienced double-digit percentage premium increases for coverage on the Health Insurance Marketplace in 2016. According to the report, averages based on proposed premium changes are not a reliable indicator of what typical consumers will actually pay because tax credits reduce the cost of coverage for the vast majority of people, shopping gives all consumers a chance to find the best deal, and public rate review can bring down proposed increases.

"Our analysis highlights how different the premiums that people actually pay are from the rates that are initially proposed by issuers," Richard Frank, Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services said. "Consumers' actual health insurance premiums depend on whether they shop around for the best deal and the availability of tax credits that lower premium costs, both of which changed the picture dramatically in 2016."

So why did the announced changes differ so dramatically from consumers' actual experience?

- **Tax credits go up along with premiums.** 85% of Marketplace consumers in Iowa receive tax credits, which are designed to protect consumers from premium increases and help make coverage affordable. Tax credits increase if the cost of the second lowest-cost silver, or benchmark, plan goes up. So if all premiums in a market go up by similar amounts, 85% of Marketplace consumers in that market will not necessarily pay more because their tax credits will go up to compensate. Average rate increases reported with the preliminary rate filings do not account for tax credits.
- **The ACA Marketplaces help consumers shop around for the best deal.** Prior to the ACA, it was nearly impossible for consumers to compare plans and shop around easily – and many Americans went uninsured because they couldn't afford insurance or had pre-existing conditions. Those who did have insurance in the individual market were often trapped in the plan they had, since people with even small health problems could be denied coverage or charged an exorbitant price if they tried to switch plans or issuers. Today, Marketplace consumers in Iowa can purchase any available plan regardless of health conditions, and tools such as the doctor lookup and out-of-pocket cost calculator help them find the plan that meets their needs. Last year, 31% of returning Marketplace consumers in Iowa switched plans. They saved an average of \$588 annually.

In contrast, average rate changes reported in rate filings assume that all consumers stick with their current health insurance plan. In particular, they assume that no consumers enroll in any new plans offered for 2017, even though new plans frequently offer lower prices. This doesn't reflect reality, given that 59% of Iowa Marketplace – including all new and 31% of returning Marketplace consumers - selected a new plan for 2016.

- *Preliminary rates aren't final rates.* Preliminary rates often change significantly before being finalized. In particular, they are subject to state regulator review, which led to \$1.5 billion in savings for consumers in 2015.

Prior to the Affordable Care Act, we lived in a world where double-digit premium increases were the norm, and that was typically for inferior plans that excluded services like maternity care, or even routine services like prescription drugs. Plans also often charged a higher premium, or denied coverage altogether, to consumers due to a pre-existing condition. Now, all consumers have the option to purchase quality, affordable coverage.

- This is a big deal for as many as 1.3 million people in Iowa with a pre-existing condition.

Today, consumers in Iowa have options.

- For 2016 coverage, 63% of customers in Iowa had the option of selecting a plan with a premium of \$75 or less per month after tax credits.
- While we expect competition to fluctuate from year-to-year, consumer choice remains strong, and 4 issuers are participating in the Marketplace, up from 3 in 2015.
- On average, consumers in Iowa could choose from 26 plans per county.

Health insurance is clearly something people in Iowa like, want, and need: 55,089 people signed up for 2016 coverage – more than ever before.

Both Marketplace and non-Marketplace consumers continue to benefit from the low health care cost growth of recent years.

- *Marketplace rates remain well below expectations when the law was passed.* Marketplace rates for 2014 came in about 15% below Congressional Budget Office (CBO) projections in 2010. Better-than-expected Marketplace premiums are due in large part to lower-than-expected economy-wide health care cost growth and other efficiencies.
- *For the half of Americans who obtain health insurance through an employer, premiums for family coverage grew by an average of 5% per year from 2010 to 2015 – compared with about 8% per year from 2000 to 2010. Premiums grew at an even slower 4.2% rate in 2015. If premium growth since 2010 had matched the average growth rate over the prior ten years, the average family premium would have been almost \$2,600 higher in 2015.*

###

Kansas Health Insurance Marketplace Premium Increases Were Not What They Seemed Last Year

A new [report](#) from the U.S. Department of Health and Human Services demonstrates that proposed premium changes from preliminary rate filings do not capture what Marketplace consumers actually pay.

The report found that, last year, the average cost of Marketplace coverage for people getting tax credits went from \$102 to \$106 per month, a 4% change, despite [suggestions](#) of “double-digit price hikes.”

The report debunks the myth—based on last year’s rate filings—that consumers experienced double-digit percentage premium increases for coverage on the Health Insurance Marketplace in 2016. According to the report, averages based on proposed premium changes are not a reliable indicator of what typical consumers will actually pay because tax credits reduce the cost of coverage for the vast majority of people, shopping gives all consumers a chance to find the best deal, and public rate review can bring down proposed increases.

“Our analysis highlights how different the premiums that people actually pay are from the rates that are initially proposed by issuers,” Richard Frank, Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services said. “Consumers’ actual health insurance premiums depend on whether they shop around for the best deal and the availability of tax credits that lower premium costs, both of which changed the picture dramatically in 2016.”

So why did the announced changes differ so dramatically from consumers’ actual experience?

- **Tax credits go up along with premiums.** 82% of Marketplace consumers in Kansas receive tax credits, which are designed to protect consumers from premium increases and help make coverage affordable. Tax credits increase if the cost of the second lowest-cost silver, or benchmark, plan goes up. So if all premiums in a market go up by similar amounts, 82% of Marketplace consumers in that market will not necessarily pay more because their tax credits will go up to compensate. Average rate increases reported with the preliminary rate filings do not account for tax credits.
- **The ACA Marketplaces help consumers shop around for the best deal.** Prior to the ACA, it was nearly impossible for consumers to compare plans and shop around easily – and many Americans went uninsured because they couldn’t afford insurance or had pre-existing conditions. Those who did have insurance in the individual market were often trapped in the plan they had, since people with even small health problems could be denied coverage or charged an exorbitant price if they tried to switch plans or issuers. Today, Marketplace consumers in Kansas can purchase any available plan regardless of health conditions, and tools such as the doctor lookup and out-of-pocket cost calculator help them find the plan that meets their needs. Last year, 63% of returning Marketplace consumers in Kansas switched plans. They saved an average of \$612 annually.

In contrast, average rate changes reported in rate filings assume that all consumers stick with their current health insurance plan. In particular, they assume that no consumers enroll in any new plans offered for 2017, even though new plans frequently offer lower prices. This doesn’t reflect reality, given that 78% of Kansas Marketplace consumers – including all new and 63% of returning Marketplace consumers - selected a new plan for 2016.

- *Preliminary rates aren’t final rates.* Preliminary rates often change significantly before being finalized. In particular, they are subject to state regulator review, which led to \$1.5 billion in savings for consumers in 2015.

Prior to the Affordable Care Act, we lived in a world where double-digit premium increases were the norm, and that was typically for inferior plans that excluded services like maternity care, or even routine services like prescription drugs. Plans also often charged a higher premium, or denied coverage altogether, to consumers due to a pre-existing condition. Now, all consumers have the option to purchase quality, affordable coverage.

- This is a big deal for as many as 1.2 million people in Kansas with a pre-existing condition.

Today, consumers in Kansas have options.

- For 2016 coverage, 62% of customers in Kansas had the option of selecting a plan with a premium of \$75 or less per month after tax credits.
- While we expect competition to fluctuate from year-to-year, consumer choice remains strong, and 4 issuers are participating in the Marketplace.
- On average, consumers in Kansas could choose from 26 plans per county.

Health insurance is clearly something people in Kansas like, want, and need: 101,555 people signed up for 2016 coverage – more than ever before.

Both Marketplace and non-Marketplace consumers continue to benefit from the low health care cost growth of recent years.

- *Marketplace rates remain well below expectations when the law was passed.* Marketplace rates for 2014 came in about 15% below Congressional Budget Office (CBO) projections in 2010. Better-than-expected Marketplace premiums are due in large part to lower-than-expected economy-wide health care cost growth and other efficiencies.
- *For the half of Americans who obtain health insurance through an employer,* premiums for family coverage grew by an average of 5% per year from 2010 to 2015 – compared with about 8% per year from 2000 to 2010. Premiums grew at an even slower 4.2% rate in 2015. If premium growth since 2010 had matched the average growth rate over the prior ten years, the average family premium would have been almost \$2,600 higher in 2015.

###

Missouri Health Insurance Marketplace Premium Increases Were Not What They Seemed Last Year

A new [report](#) from the U.S. Department of Health and Human Services demonstrates that proposed premium changes from preliminary rate filings do not capture what Marketplace consumers actually pay. The report found that, last year, the average cost of Marketplace coverage for people getting tax credits went from \$102 to \$106 per month, a 4% change, despite [suggestions](#) of “double-digit price hikes.”

The report debunks the myth—based on last year’s rate filings—that consumers experienced double-digit percentage premium increases for coverage on the Health Insurance Marketplace in 2016. According to the report, averages based on proposed premium changes are not a reliable indicator of what typical consumers will actually pay because tax credits reduce the cost of coverage for the vast majority of people, shopping gives all consumers a chance to find the best deal, and public rate review can bring down proposed increases.

“Our analysis highlights how different the premiums that people actually pay are from the rates that are initially proposed by issuers,” Richard Frank, Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services said. “Consumers’ actual health insurance premiums depend on whether they shop around for the best deal and the availability of tax credits that lower premium costs, both of which changed the picture dramatically in 2016.”

So why did the announced changes differ so dramatically from consumers’ actual experience?

- **Tax credits go up along with premiums.** 87% of Marketplace consumers in Missouri receive tax credits, which are designed to protect consumers from premium increases and help make coverage affordable. Tax credits increase if the cost of the second lowest-cost silver, or

benchmark, plan goes up. So if all premiums in a market go up by similar amounts, 87% of Marketplace consumers in that market will not necessarily pay more because their tax credits will go up to compensate. Average rate increases reported with the preliminary rate filings do not account for tax credits.

- **The ACA Marketplaces help consumers shop around for the best deal.** Prior to the ACA, it was nearly impossible for consumers to compare plans and shop around easily – and many Americans went uninsured because they couldn't afford insurance or had pre-existing conditions. Those who did have insurance in the individual market were often trapped in the plan they had, since people with even small health problems could be denied coverage or charged an exorbitant price if they tried to switch plans or issuers. Today, Marketplace consumers in Missouri can purchase any available plan regardless of health conditions, and tools such as the doctor lookup and out-of-pocket cost calculator help them find the plan that meets their needs. Last year, 41% of returning Marketplace consumers in Missouri switched plans. They saved an average of \$372 annually.

In contrast, average rate changes reported in rate filings assume that all consumers stick with their current health insurance plan. In particular, they assume that no consumers enroll in any new plans offered for 2017, even though new plans frequently offer lower prices. This doesn't reflect reality, given that 64% of Missouri Marketplace consumers – including all new and 41% of returning Marketplace consumers - switched plans last year.

- *Preliminary rates aren't final rates.* Preliminary rates often change significantly before being finalized. In particular, they are subject to state regulator review, which led to \$1.5 billion in savings for consumers in 2015.

Prior to the Affordable Care Act, we lived in a world where double-digit premium increases were the norm, and that was typically for inferior plans that excluded services like maternity care, or even routine services like prescription drugs. Plans also often charged a higher premium, or denied coverage altogether, to consumers due to a pre-existing condition. Now, all consumers have the option to purchase quality, affordable coverage.

- This is a big deal for as many as 2.6 million people in Missouri with a pre-existing condition.

Today, consumers in Missouri have options.

- For 2016 coverage, 71% of customers in Missouri had the option of selecting a plan with a premium of \$75 or less per month after tax credits.
- While we expect competition to fluctuate from year-to-year, consumer choice remains strong, and 7 issuers are participating in the Marketplace, up from 4 in 2014.
- On average, consumers in Missouri could choose from 37 plans per county.

Health insurance is clearly something people in Missouri like, want, and need: 290,201 people signed up for 2016 coverage – more than ever before.

Both Marketplace and non-Marketplace consumers continue to benefit from the low health care cost growth of recent years.

- *Marketplace rates remain well below expectations when the law was passed.* Marketplace rates for 2014 came in about 15% below Congressional Budget Office (CBO) projections in 2010. Better-than-expected Marketplace premiums are due in large part to lower-than-expected economy-wide health care cost growth and other efficiencies.

- For the half of Americans who obtain health insurance through an employer, premiums for family coverage grew by an average of 5% per year from 2010 to 2015 – compared with about 8% per year from 2000 to 2010. Premiums grew at an even slower 4.2% rate in 2015. If premium growth since 2010 had matched the average growth rate over the prior ten years, the average family premium would have been almost \$2,600 higher in 2015.

###

Nebraska Health Insurance Marketplace Premium Increases Were Not What They Seemed Last Year

A new [report](#) from the U.S. Department of Health and Human Services demonstrates that proposed premium changes from preliminary rate filings do not capture what Marketplace consumers actually pay. In Nebraska, the average Marketplace premium among people with tax credits went from \$104 last year to \$105 per month in 2016, a modest 1% change, despite [reports](#) based on preliminary rate filings predicting “double-digits rate increases.”

The report debunks the myth—based on last year’s rate filings—that consumers experienced double-digit percentage premium increases for coverage on the Health Insurance Marketplace in 2016. According to the report, averages based on proposed premium changes are not a reliable indicator of what typical consumers will actually pay because tax credits reduce the cost of coverage for the vast majority of people, shopping gives all consumers a chance to find the best deal, and public rate review can bring down proposed increases.

“Our analysis highlights how different the premiums that people actually pay are from the rates that are initially proposed by issuers,” Richard Frank, Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services said. “Consumers’ actual health insurance premiums depend on whether they shop around for the best deal and the availability of tax credits that lower premium costs, both of which changed the picture dramatically in 2016.”

So why did the announced changes differ so dramatically from consumers’ actual experience?

- **Tax credits go up along with premiums.** 88% of Marketplace consumers in Nebraska receive tax credits, which are designed to protect consumers from premium increases and help make coverage affordable. Tax credits increase if the cost of the second lowest-cost silver, or benchmark, plan goes up. So if all premiums in a market go up by similar amounts, 88% of Marketplace consumers in that market will not necessarily pay more because their tax credits will go up to compensate. Average rate increases reported with the preliminary rate filings do not account for tax credits.
- **The ACA Marketplaces help consumers shop around for the best deal.** Prior to the ACA, it was nearly impossible for consumers to compare plans and shop around easily – and many Americans went uninsured because they couldn’t afford insurance or had pre-existing conditions. Those who did have insurance in the individual market were often trapped in the plan they had, since people with even small health problems could be denied coverage or charged an exorbitant price if they tried to switch plans or issuers. Today, Marketplace consumers in Nebraska can purchase any available plan regardless of health conditions, and tools such as the doctor lookup and out-of-pocket cost calculator help them find the plan that meets their needs. Last year, 37% of returning Marketplace consumers in Nebraska switched plans. They saved an average of \$336 annually.

In contrast, average rate changes reported in rate filings assume that all consumers stick with their current health insurance plan. In particular, they assume that no consumers enroll in any new plans offered for 2017, even though new plans frequently offer lower prices. This doesn’t reflect reality,

given that 61% of Nebraska Marketplace consumers – including all new and 37% of returning Marketplace consumers - selected a new plan for 2016.

- *Preliminary rates aren't final rates.* Preliminary rates often change significantly before being finalized. In particular, they are subject to state regulator review, which led to \$1.5 billion in savings for consumers in 2015.

Prior to the Affordable Care Act, we lived in a world where double-digit premium increases were the norm, and that was typically for inferior plans that excluded services like maternity care, or even routine services like prescription drugs. Plans also often charged a higher premium, or denied coverage altogether, to consumers due to a pre-existing condition. Now, all consumers have the option to purchase quality, affordable coverage.

- This is a big deal for as many as 767,000 people in Nebraska with a pre-existing condition.

Today, consumers in Nebraska have options.

- For 2016 coverage, 69% of customers in Nebraska had the option of selecting a plan with a premium of \$75 or less per month after tax credits.
- While we expect competition to fluctuate from year-to-year, consumer choice remains strong, and 4 issuers are participating in the Marketplace, up from 2 in 2015.
- On average, consumers in Nebraska could choose from 31 plans per county.

Health insurance is clearly something people in Nebraska like, want, and need: 87,835 people signed up for 2016 coverage – more than ever before.

Both Marketplace and non-Marketplace consumers continue to benefit from the low health care cost growth of recent years.

- *Marketplace rates remain well below expectations when the law was passed.* Marketplace rates for 2014 came in about 15% below Congressional Budget Office (CBO) projections in 2010. Better-than-expected Marketplace premiums are due in large part to lower-than-expected economy-wide health care cost growth and other efficiencies.
- *For the half of Americans who obtain health insurance through an employer,* premiums for family coverage grew by an average of 5% per year from 2010 to 2015 – compared with about 8% per year from 2000 to 2010. Premiums grew at an even slower 4.2% rate in 2015. If premium growth since 2010 had matched the average growth rate over the prior ten years, the average family premium would have been almost \$2,600 higher in 2015.

###

NEW: Notices Have Been Mailed to Consumers Who May Be Enrolled in Marketplace Coverage with APTC or CSRs and Medicaid or CHIP (also called Periodic Data Matching)

Key Takeaway: This month, the Marketplace will mail paper notices to the household contacts of consumers who may be enrolled in a Marketplace plan with APTC or income-based CSRs and Medicaid or CHIP that qualifies as minimum essential coverage (MEC), with instructions on what to do next. Consumers determined eligible for [MEC](#)* Medicaid or CHIP are not eligible for a Marketplace plan with APTC or income-based CSRs. If consumers who get this notice contact assisters with questions, assisters can help them understand the notice and complete the necessary next steps.*

Overview

If a Marketplace confirms Medicaid or CHIP enrollment through a periodic data matching (PDM) process, or a consumer who has APTC reports enrollment in Medicaid or CHIP during the coverage year, the Marketplace must accept the state's decision as a valid eligibility determination and the consumer's eligibility for APTC must be updated to reflect that he or she has other MEC. Therefore, those consumers who are identified as being enrolled in Medicaid or CHIP through the periodic data matching process should return to their application and either end their Marketplace coverage or end their APTC such that financial assistance is no longer being used to cover the consumer.

PDM is the process the Marketplace uses to identify consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers). This month, as part of PDM, the Marketplace mailed paper notices to the household contact for any consumers it found to be dually-enrolled.** The notices tell consumers to either: immediately end their Marketplace coverage with APTC/CSRs if they are enrolled in Medicaid or CHIP, with instructions on how to do so; or to take no further action if they are no longer enrolled in Medicaid or CHIP.

- See [this](#) paper to understand the differences between receiving a data matching issue (DMI) notice and a periodic data matching issue (PDM) notice.

*Most Medicaid or CHIP is considered MEC. Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) and aren't considered MEC. (For more information on which Medicaid programs are considered MEC, visit: HealthCare.gov/medicaid-limited-benefits/).

** Consumers in the following states will not receive notices in this round of PDM: GA, ME, NH, NJ, and WY.

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

Q1: Who does this notice impact?

A1: This notice impacts consumers who are enrolled in both a Marketplace plan with APTC or income-based CSRs and Medicaid or CHIP. Consumers who were identified as enrolled in both a Marketplace plan with APTC/CSRs and Medicaid or CHIP will be notified. Consumers in the following states will not receive notices in this round of PDM: GA, ME, NH, NJ, and WY.

Q2: Why is this important for consumers?

A2: If a Marketplace confirms Medicaid or CHIP enrollment through PDM, the consumer's eligibility for APTC must be updated to reflect that he or she has other MEC. These consumers should be encouraged to return to their application to end their Marketplace coverage with APTC.

If such consumers still want a Marketplace plan after having been determined eligible for Medicaid or CHIP, they will have to pay full price for their share of the Marketplace plan.

Q3: What is the impact on consumers who are enrolled in both Medicaid or CHIP and a Marketplace plan with APTC/CSRs?

A3: Consumers who are enrolled in both a Marketplace plan with APTC/CSRs and Medicaid or CHIP are not eligible for advance payments of the premium tax credit or cost-sharing reductions. Therefore, those consumers who are enrolled in Medicaid or CHIP are encouraged to return to their application and either end their Marketplace coverage or end their APTC such that financial assistance is no longer being used to cover the consumer.

Q4: When and how are these notices being sent to consumers?

A4: The Marketplace mailed paper notices in May 2016 to the household contact for applications with consumers who may be dually-enrolled. The notices are not available electronically in consumer user accounts. Additional data matching and notifying of consumers will occur at a later date in 2016; updates will be provided when more information is available.

Q5: How will consumers identify these notices, and what do the notices say?

A5: The subject of the notice reads “Warning: People in your household may no longer be eligible for financial help for their Marketplace coverage.” The notice lists the consumers the Marketplace found to be dually-enrolled, and tells them to do one of two things: 1) if they are enrolled in MEC Medicaid or CHIP, immediately end their Marketplace coverage with APTC/CSRs (the notice provides instructions on how to do so); or 2) take no further action if they are no longer enrolled in Medicaid or CHIP. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, or if they aren't sure if their Medicaid or CHIP coverage qualifies as MEC, OR if they aren't sure whether they are enrolled in Medicaid or CHIP. Copies of the notices sent to consumers are available in [English](#) and [Spanish](#).

- Notice in English: <https://marketplace.cms.gov/applications-and-forms/pdm-round-2-notice.pdf>
- Notice in Spanish: <https://marketplace.cms.gov/applications-and-forms/pdm-round-2-notice-spanish.pdf>

Q6: As an assister, why might consumers contact me, and how can I help them?

A6: Consumers who receive the notice may contact assisters: (a) for help understanding the notice; (b) for help ending Marketplace coverage with APTC/CSRs; (c) if they don't think they're enrolled in MEC Medicaid or CHIP, or aren't sure if they are, or aren't sure if their Medicaid or CHIP coverage qualifies as MEC; and/or (d) if they want more information about Medicaid or CHIP. Here are some examples of the ways that assisters can help consumers who contact them:

(A) Help consumers understand the notice. Explain that this notice has been sent to them because the Marketplace has identified them as being dually-enrolled in Marketplace coverage with APTC/CSRs as well as Medicaid or CHIP. This is important because consumers who have been determined eligible for Medicaid or CHIP are not eligible for a Marketplace plan with APTC/CSRs; these consumers must end their Marketplace coverage with APTC/CSRs immediately.

- See [this](#) presentation on how the Marketplace conducts Periodic Data Matching and how you can help consumers resolve DMIs:

(B) Encourage consumers who are enrolled in Medicaid or CHIP to take immediate action to end their Marketplace coverage with APTC/CSRs.

- See [this](#) presentation for more information on the process for helping consumers end their Marketplace coverage with APTC/CSRs.
- See [these](#) instructions on HealthCare.gov to help a consumer end Marketplace coverage altogether once determined eligible for Medicaid or CHIP.

(C) Inform consumers who don't think they're enrolled in Medicaid or CHIP or who aren't sure that they may want to contact their state Medicaid or CHIP agency to confirm their enrollment status. If the state agency confirms that the consumer is not enrolled in Medicaid or CHIP coverage, no further action is needed with the Marketplace.

(D) Advise consumers who want more information about Medicaid or CHIP to contact their state Medicaid or CHIP agency.

Q7: What if the consumer is enrolled in Medicaid or CHIP but believes he or she is actually eligible to remain enrolled in Marketplace coverage with APTC/CSRs?

A7: A consumer may be enrolled in Medicaid or CHIP and Marketplace coverage with APTC/CSRs, but has experienced a household or income change that makes him or her ineligible for Medicaid or CHIP. The consumer should contact his or her state Medicaid or CHIP agency to inform them of the change and receive a redetermination of eligibility for Medicaid or CHIP. If the consumer is found to no longer be eligible for Medicaid or CHIP, his or her coverage will end; the consumer can remain in Marketplace coverage with APTC/CSRs, if otherwise eligible.

###

NEW: Special Enrollment Period Eligibility Updates

On May 6, 2016, The Department of Health and Human Services announced updates to the [requirements for certain special enrollment periods](#) (SEPs) available to consumers through the Marketplace and clarified the [six defined categories](#) for which SEPs are available.

Changes to the Permanent Move SEP

Beginning July 11, 2016 individuals requesting a “permanent move” SEP must have minimum essential coverage for one or more days in the 60 days before their move, unless they were living outside of the United States or in a United State territory prior to the permanent move.

Changes to Maintain SEP Eligibility for Individuals Who Were Incarcerated or Previously in the Medicaid Gap

Additionally, the rules include changes to ensure that individuals who 1) were incarcerated, or 2) were previously in the coverage gap in a non-Medicaid expansion state and have moved and become newly eligible for advance payments of the premium tax credit, may continue to qualify for a special enrollment period. Both of these populations would have previously qualified for the permanent move SEP.

The Six SEP Categories

SEPs are available in [six defined circumstances](#): (1) losing other qualifying coverage, (2) changes in household size like marriage or birth, (3) changes in residence, (4) changes in eligibility for financial help, (5) experiencing defined types of errors made by Marketplaces or plans, and (6) (6) other specific cases, including exceptional circumstances like natural disasters.

For more information on these SEP changes, click [here](#).

###

NEW: Loan Discharges for Those with Total and Permanent Disabilities Are Counted as Income

The U.S. Department of Education and the Social Security Administration recently [released guidance](#) that addresses benefits protections for consumers with Total and Permanent Disabilities (TPD) who are eligible for a loan discharge.

Someone who cannot work at any job due to a long-term disability may receive a TPD designation. TPD designees may receive a discharge, or forgiveness of their federal student loans, so they will no longer be held responsible for making their student loan payments, but the amount of their discharge must be reported to the Marketplace.

The guidance clarifies that the loan discharge amount TPD eligible consumers receive is generally considered taxable income for the year the discharge becomes final, except for households whose loan discharge exceeds their net assets. The loan discharge amount is considered part of a borrower's countable income ([Modified Adjusted Gross Income](#)) and is used to determine eligibility for advance payments of the premium tax credit for coverage obtained through the Marketplace.

In your work with TPD-eligible consumers, let them know that they must report the amount of loan forgiveness as taxable income on their Marketplace application **in the year the discharge is scheduled to become final**. Additional information that may be helpful in your work with this population include:

- [What counts as income on the Marketplace Application?](#)

- [How to estimate the income to report on a Marketplace Application](#)
- [Learn more about Total and Permanent Disabilities \(TPD\) Student Loan forgiveness](#)

In general, it is important for Marketplace consumers to report any income changes, including loan discharges, to the Marketplace as soon as possible. Assisters should inform consumers that their failure to do so could result in their either missing out on subsidies or having to pay back any subsidies received when they file federal income taxes for the year.

###

NEW: CMS Seeks Comments on Proposed Changes to the Navigator Reporting Requirements

On May 11th, CMS published a Paperwork Reduction Act (PRA) package with proposed changes to the Navigator reporting requirements. The proposed changes are designed to better capture the vast array of work being done by our Navigator grantees beyond QHP enrollments. Comments will be accepted between now and July 11, 2016.

Key Information

- **PRA Package Name:** Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges
- **Date Posted:** May 11, 2016
- **Comments Due:** July 11, 2016
- **Date Final:** late September 2016
- **Submit Comments:** <https://www.federalregister.gov/articles/2016/05/11/2016-11078/agency-information-collection-activities-proposed-collection-comment-request>
- **Supporting Documents:** <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10463.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>

###

NEW: Conflict of Interest Guidance for Assisters

Last week, we published guidance for assisters on how to comply with the conflict of interest requirements that apply to you. The guidance explains who in your organization needs to comply with the conflict of interest requirements, what kinds of relationships are prohibited, what kinds of relationships must be disclosed and to whom, and it includes in-depth discussions of the prohibition on receiving consideration in connection with enrollment, and to what extent staff members of health insurance issuers can serve as assisters.

- Click [here](#) to read the Tip Sheet: Federally-facilitated Marketplace Assister Conflict of Interest Requirements

###

Reminder: Coverage to Care

Open enrollment ended on January 31, 2016 with about 13 million consumers having selected plans through Health Insurance Marketplaces.

Now that many Americans have an insurance card, what's the next step? The Center for Medicare & Medicaid Services has developed many resources to help consumers understand how to make the most of

their new coverage. Our “From Coverage to Care” initiative offers user-friendly resources that explain what health coverage is and aims to help consumers use their coverage to access routine primary care and preventive services. Materials are available in multiple languages and provide an eight-step roadmap intended to guide the newly insured through the process of navigating the health care system. Each step includes checklists and recommendations for how to connect to care. CMS is accepting requests for professional print-ready versions of any of our resources at coveragetocare@cms.hhs.gov.

For more information about this initiative click [here](#).

###

Reminder: Failure to Reconcile- Helping Consumers Understand and Take Action

The Marketplace may not determine a tax filer eligible for advance payments of the premium tax credit (APTC) if APTC was previously provided on behalf of the tax filer and the tax filer did not comply with the requirement to file an income tax return for the year during which APTC was provided and reconcile APTC.

Consumers who received APTC in 2014 but did not file a 2014 tax return were flagged as “failure to file and reconcile”—or FTR—by the Internal Revenue Service (IRS) when the Marketplace requested updated tax data. Beginning with Open Enrollment 2016, the Federally-facilitated Marketplace (“Marketplace”) discontinued APTC and income-based cost-sharing reductions (CSRs) for 2016 coverage for enrollees flagged as FTR.

Due to lags in IRS data updates, the Marketplace included a new tax filing-related question in the 2016 Marketplace application that allowed enrollees who received APTC for 2014 to attest, under penalty of perjury and other applicable laws, to having filed a 2014 tax return and reconciled APTC. This attestation allowed enrollees to maintain APTC even if IRS’ data has not yet reflected that they had filed.

In May 2016, the Marketplace will conduct a recheck of IRS data to identify 2016 applications of consumers:

1. Who told the Marketplace that they filed and reconciled 2014 APTC; and
2. For whom IRS data indicates they received APTC in 2014 but have not filed a 2014 tax return (“recheck population”).

Following this recheck in May, the Marketplace will send an FTR warning notice to the household contact for applications for which IRS still indicates that they have not filed a 2014 tax return. This warning notice will tell consumers that they must, first, make sure they filed and reconciled 2014 APTC and if not, file and reconcile APTC immediately or the Marketplace will take action to end their APTC.

What Assisters Can Do:

- Encourage enrollees who haven’t yet filed their 2014 federal income taxes and who received APTC in 2014 to file and reconcile their APTC **as soon as possible**. **Filing in early June will best protect consumers from losing APTC.**
- Remind enrollees that even if they usually don’t have to file an income tax return, if they received APTC, they must file a return for that year.
- Help enrollees who haven’t filed their taxes yet understand what steps to take, including helping them access their Forms 1095-A and report any errors.

For more information, including how you as an assister can help consumers, check out the slides from the Friday May 13th Assister Webinar [here](#).

###

Medicare and Medicaid Updates

Information You Need: Medicare's Equipment and Supplies Program in Your Community

If you help people with Original Medicare who need certain medical equipment and supplies, such as oxygen, walkers and wheelchairs, you should know that Medicare is continuing its successful Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, which has been in place for many areas throughout the country. This program is an essential tool to help Medicare set appropriate payment rates for DMEPOS items, save money for beneficiaries and taxpayers, and ensure access to quality items.

The link below contains the latest information about the program. Please share it through your member newsletters or other channels that reach people with Medicare.

We appreciate your assistance.

<https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/DMEPOSPartnerArticleMay2016.pdf>

###

Multi-Payer Advanced Primary Care Practice Demonstration

The Centers for Medicare & Medicaid Services (CMS) released the Second Annual Report and Third Annual Report of the evaluation of the Multi-Payer Advanced Primary Care Practice Demonstration. The Second Annual Report contains quantitative cost, utilization and quality of care findings from the first 8 demonstration quarters and qualitative findings from the Year 2 site visits. The Third Annual Report contains qualitative findings from the final round of site visits (no quantitative results).

For additional information, on the evaluation reports click here:

- Second annual report: <https://downloads.cms.gov/files/cmmi/mapcp-secondevalrpt.pdf>
- Third annual report: <https://downloads.cms.gov/files/cmmi/mapcp-thirdevalrpt.pdf>

###

Medicare Learning Network Announcements

MLN Connects® Events

- [2015 Mid-Year QRURs Webcast — Last Chance to Register](#)

Medicare Learning Network® Publications and Multimedia

- [Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims MLN Matters® Article — Revised](#)
- [Transitional Care Management Services Fact Sheet — Revised](#)
- [Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Fact Sheet — Revised](#)
- [DMEPOS Competitive Bidding Program Fact Sheets — Revised](#)

Announcements

- [Updates to Data Initiatives Increase Transparency of the Medicare Program](#)

- [HHS Awards over \\$260 Million to Health Centers Nationwide to Build and Renovate Facilities to Serve More Patients](#)
- [Open Payments: Physician and Teaching Hospital Review and Dispute Period Ends May 15](#)
- [2016 Electronic Clinical Quality Measures: Updated Files Available](#)
- [Teaching Hospitals: Submitting Medicare GME Affiliation Agreements](#)
- [May is National Osteoporosis Month](#)

Claims, Pricers, and Codes

- [Coinsurance Correction for Certain RHC Claims](#)
- [Billing Requirements for RHCs](#)

MLN Connects® Events

- [New Audio Recordings and Transcripts Available](#)

Other CMS Events

- [Comparative Billing Report on Psychotherapy and E/M Services Webinar](#)

Medicare Learning Network® Publications and Multimedia

- [Part C Appeals: Organization Determinations, Appeals, and Grievances WBT — Revised](#)
- [Part D Coverage Determinations, Appeals, and Grievances WBT — Revised](#)
- [Resources for Medicare Beneficiaries Booklet — Revised](#)
- [How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised](#)
- [Updated MLN Matters® Search Indices](#)

Announcements

- [2017 Medicare Shared Savings Program: Notice of Intent to Apply Period Closes May 31](#)
- [SNF Value-Based Purchasing Program: Specifications for New Measure](#)
- [2014 PQRS Experience Report Available](#)
- [How to Use ICD-10 and Maintain Your Progress](#)
- [Talk to Your Patients about Mental Health](#)

###

Medicare Parts C and D Program Integrity

Learn from CMS' Division of Plan Oversight and Accountability (DPOA) about the latest developments in Medicare Parts C and D program integrity. Visit the O&E MEDIC website to read the March 2016, April 2016 and May 2016 issues of [Medicare Parts C & D Integrity News](#).

The newsletter summarizes recent:

- New Releases
- Reports and Testimony
- Health Care Industry Developments
- Federal Register Information
- Enforcement Actions

- Medicare Program Guidance

###

Monitoring Data Shows Adequacy of New Payment Amounts for DMEPOS in Non-Competitively Bid Areas: *Results Suggest No Negative Impact on Beneficiary Access in Urban and Rural Areas*

Starting in 2011, section 1834(a)(1)(F) of the Social Security Act (the Act) required CMS to use competitive bidding to set payment amounts for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for certain areas in the country. As implementation of the DMEPOS competitive bidding program has rolled out in areas across the country, CMS has been using real-time data monitoring to ensure that Medicare beneficiaries continue to receive the medical equipment they need. This data monitoring tracks access to items and services and a number of clinical outcome measures such as mortality, hospitalizations, and emergency room visits. By all measures, the DMEPOS competitive bidding program has been a great success for beneficiaries and the taxpayers.

Section 1834(a)(1)(F) of the Act also required that the DMEPOS fee schedule amounts paid in non-competitive bidding areas be adjusted based on information from the competitive bidding program beginning on January 1, 2016. CMS started to phase-in these new rates with a blend of 50 percent of the unadjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts on January 1, 2016. CMS is using the same monitoring system we use in competitive bidding areas to ensure beneficiaries are receiving the equipment they need.

The [monitoring data](#) posted today shows that suppliers in all areas where the adjusted DMEPOS fee schedule rates have been implemented have continued to accept these adjusted rates as payment in full, suggesting that the adjusted fee schedule rates continue to be more than adequate in covering the costs of furnishing the DMEPOS items in all areas.

A valuable indicator of whether payment amounts are sufficient is the percentage of claims that suppliers submit as accepting assignment, meaning that the suppliers accept the Medicare fee schedule amount as payment in full. Suppliers in non-competitive bidding areas are not required to accept assignment of Medicare claims for DMEPOS items in accordance with the Medicare statute. This means that if an adjusted fee schedule amount is not sufficient to cover the costs of furnishing the item to a particular beneficiary in the supplier's service area because of where the beneficiary lives or for other reasons, the supplier can decide not to accept assignment of the claim and can collect the extra money to cover their costs directly from the beneficiary. This payment from the beneficiary would be in addition to the coinsurance and deductible required by all beneficiaries for DMEPOS items.

The monitoring data posted today compares the rate of assignment of claims for DMEPOS items for the first four months of 2015 that were paid at the unadjusted fee schedule rates versus the rate of assignment of claims for the same items that were paid at the new partially adjusted rates for the first four months of 2016.

The data are broken out for eight geographic regions of the contiguous United States, as well as non-contiguous areas (i.e., Alaska, Hawaii, Puerto Rico, Virgin Islands, etc., combined). The data are also broken out to compare the rate of assignment of claims for DMEPOS items furnished in rural areas versus

non-rural areas. The rate of assignment of claims in 2016 continues to be very high overall in both rural and non-rural areas. Finally, the data is broken out for several different categories of DMEPOS items.

Overall, there was no change in the rate of assignment for the first four months in 2016 (99.88 percent) compared to the first four months in 2015 (99.87 percent). There was also no change in the rate of assignment in rural areas in 2016 (99.90 percent) compared to 2015 (99.90 percent), while the rate of assignment in non-contiguous areas changed only slightly in 2016 (99.81 percent) compared to 2015 (99.90 percent).

The monitoring data are available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/Fee-Adjustment-Monitoring.html>

CMS expects to post additional data on assignment rates, access to items and services, and health outcomes in the near future.

Based on our monitoring efforts and the continued high voluntary acceptance of assignment across all non-competitive bidding areas, including rural areas and non-contiguous areas, CMS believes that the fee schedule adjustments implemented in January have not had a negative impact on beneficiary access to quality items and services. CMS will continue to monitor all data very closely leading up to and following the phase in of the fully adjusted DMEPOS fee schedule adjustments on July 1, 2016.

###

Upcoming Webinars and Events

CMS Hospital/Quality Initiative Open Door Forum scheduled for:

Date: Tuesday, June 7, 2016
Start Time: 2:00 PM Eastern Time (ET)
Please dial-in at least 15 minutes before call start time.

****This Agenda is Subject to Change****

I. Opening Remarks

Chair – Tiffany Swygert (Center for Medicare)
Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- 2 Midnight Rule: Temporary Suspension of QIO Medical Review
- Billing for Discarded Drugs ('JW' Modifier)
- IPPS Wage Index Update
- Upcoming Stakeholder Engagement Opportunities (IMPACT Act)
- Summary of the IRF Quality Reporting Program portion of the FY2017 IRF PPS Proposed Rule:
 - available at: <http://federalregister.gov/a/2016-09397>

III. Open Q&A

****DATE IS SUBJECT TO CHANGE****

Next CMS Hospital/Quality Initiative Open Door Forum: July 19, 2016
ODF EMAIL MAILBOX: Hospital_ODF@cms.hhs.gov

This Open Door Forum is not intended for the press, and the remarks are not considered on the record. If you are a member of the Press, you may listen in but please refrain from asking questions during the Q & A portion of the call. If you have inquiries, please contact CMS at Press@cms.hhs.gov. Thank you.

Open Door Participation Instructions:
This call will be Conference Call Only.

To participate by phone:
Dial: 1-800-837-1935 & Reference Conference ID: 41274021
Persons participating by phone do not need to RSVP. TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Encore: 1-855-859-2056; Conference ID: 41274021
Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID beginning 2 hours after the call has ended. The recording expires after 2 business days.

For ODF schedule updates and E-Mailing List registration, visit our website at <http://www.cms.gov/OpenDoorForums/>.

###

Staying in Touch: The Art of Connecting Consumers to Year Round Access:

Join us for this presentation and discussion about helping enrolled consumers navigate the health care system and understand their insurance coverage and benefits. Learn how Epilepsy Foundation and Community Health Initiative of Orange County have created systems for staying in touch with their clients and act as a reliable and trusted resource for clear and timely information. This webinar is sponsored by the HHS Partnership Center and Enroll America.

June 8 at 2:00 p.m. EDT (1:00 pm CDT, Noon MDT, 11:00 am PDT). Register [here](#).

###

CMS National Training Program Learning Series Webinar

June 9, 2016 1:00 – 2:30 pm ET

This webinar session will provide information that should help you understand when prescription drugs are covered under Medicare

- Part A (Hospital Insurance)
- Part B (Medical Insurance)
- Part D (Medicare prescription drug coverage)

Join the webinar by visiting <https://goto.webcasts.com/starthere.jsp?ei=1103889>.

###

Got Coverage? Next Steps in Using Your Health Insurance

June 9 at 2:00 pm EDT

(1:00 pm CDT, Noon MDT, 11:00 am PDT)

To RSVP and attend, [click here](#)

Many people now have health insurance but may not know how to use it. This webinar will highlight From Coverage to Care health insurance literacy tools and how to use them. The importance of preventive benefits and primary care will also be discussed. Guest speakers will highlight how they use the materials. A question and answer session will take place at the end of the webinar.

###

Out to Enroll

Please join us for a special assister webinar in partnership with [Out2Enroll](#) on reaching and assisting lesbian, gay, bisexual, and transgender (LGBT) communities. Assister organizations that take the training webinar can get listed in Out2Enroll's [web tool](#) that allows LGBT consumers to search for LGBT-friendly assisters in their area. You can contact Out2Enroll at info@out2enroll.org to learn more about the tool.

Friday, June 10 from 2:00 pm to 3:30 pm ET. [Click here to register for this presentation.](#)

###

Webinar: Addressing the Behavioral Health Needs of Transgender & Gender Non-Conforming Patients

Monday, June 13, 2016

8 am HDT / 11 am PDT / 12 pm MDT / 1 pm CDT / 2 pm EDT (*please note the time for your location*)

This 90 minute webinar aims to build competency to address the behavioral health needs of transgender and gender non-conforming patients in a culturally appropriate manner and will feature promising practices of Health Resources and Services Administration (HRSA) grantees. Additionally, the U.S. Department of Health and Human Services, Office for Civil Rights will discuss the recently approved nondiscrimination rule under Section 1557 of the Affordable Care Act.

The target audience includes HRSA grantees, healthcare providers, public health officials, and advocates wanting to improve competency in regards to serving the needs of transgender and gender non-conforming patients in their practices.

Free registration in advance is required and space is limited. Please feel free to share this announcement with your colleagues.

For more information, please contact Valerie Gallo at 415-437-8095 or vgallo@hrsa.gov

TO REGISTER, PLEASE GO TO:

https://hrsaseminar.adobeconnect.com/addressing_needs-event/event/registration.html

AGENDA

How HRSA Is Improving the Lives of the LGBT Community

Valerie Gallo, MPH - Public Health Analyst
Christina Mead, PharmD - Regional Pharmacy Consultant
Kim Patton, PsyD - Public Health Analyst
HRSA Office of Regional Operations

Making Your Clinic Space Trans* Friendly / Behavioral Health Issues Affecting the Trans* Community

Tricia Smith, ACSW - Medical Social Worker for Primary, Trans* and Women's Health Programs
Los Angeles LGBT Center

Integrating Trans* Friendly Behavioral Health into Primary Care

Sandra Hall, LCSW - Mental Health Director
Lyon-Martin Health Services (a program of HealthRight 360)

Patient Protection and Affordable Care Act Prohibits Discrimination

Ian Shipps, J.D. - Supervisory Investigator
Office for Civil Rights, U.S. Department of Health and Human Services

###

Special Enrollment Periods and Resources for the Uninsured

June 14 at 3:00 pm EDT

(2:00 pm CDT, 1:00 MDT, Noon PDT)

To RSVP and attend, [click here](#)

Getting married or graduating from college this spring? The health care law has created special enrollment periods for those who experience special circumstances such as graduating from college and losing health insurance, getting married and needing coverage for a spouse, losing employer insurance or turning 26 and losing coverage on a parent's health plan. Join this webinar to learn more about special enrollment periods and how to enroll in the Health Insurance Marketplace. For those who are uninsured and don't qualify for the special enrollment [More...](#)period, learn what resources are available and when to enroll in the Health Insurance Marketplace. Questions and answers will be discussed at the end of the webinar.

###

Got Coverage? Next Steps in Using Your Health Insurance

July 14 at 2:00 pm EDT

(1:00 pm CDT, Noon MDT, 11:00 am PDT)

To RSVP and attend, [click here](#)

Many people now have health insurance but may not know how to use it. This webinar will highlight From Coverage to Care health insurance literacy tools and how to use them. The importance of preventive benefits and primary care will also be discussed. Guest speakers will highlight how they use the materials. A question and answer session will take place at the end of the webinar.

###

Centers for Medicare & Medicaid Services - Special Open Door Forum:

Inpatient Rehabilitation Facility Tier Comorbidity Updates:

Soliciting Stakeholder Input

Thursday, June 16, 2016

2:00-3:30 pm Eastern Time

Conference Call Only

CMS will host a Special Open Door Forum (ODF) to allow inpatient rehabilitation facilities (IRFs) and other stakeholders to provide input and suggestions to CMS regarding the areas of most concern or interest for updating the tier comorbidity portion of IRF payments.

The purpose of the Inpatient Rehabilitation Facility Tier Comorbidity Updates project is to update the tier comorbidities used in calculating Medicare payments for IRF services so that IRF payments align as closely as possible with the costs of providing the services. CMS is working with Acumen, LLC to analyze the tier comorbidities list and policies, which were last updated in fiscal years 2006 and 2007. We are seeking stakeholder input as we begin this process to ensure that we include in our analysis all stakeholder comments and areas of concern.

Here is the link to "Data Files" page that has the slides and the current list of tier comorbidities used in determining IRF payments: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html>

Feedback and questions on the Inpatient Rehabilitation Facility Tier Comorbidity Updates project can be sent to: IRFCoverage@cms.hhs.gov

We look forward to your participation.

Special Open Door Participation Instructions:

Participant Dial-In Number: 1-866-778-8325

Conference ID #: 77742091

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.gov/OpenDoorForums/>.

###

Special Enrollment Periods and Resources for the Uninsured

July 19 at 2:00 pm EDT

(1:00 pm CDT, Noon MDT, 11:00 am PDT)

To RSVP and attend, [click here](#)

Getting married or graduating from college this spring? The health care law has created special enrollment periods for those who experience special circumstances such as graduating from college and losing health insurance, getting married and needing coverage for a spouse, losing employer insurance or turning 26 and losing coverage on a parent's health plan. Join this webinar to learn more about special enrollment periods and how to enroll in the Health Insurance Marketplace. For those who are uninsured and don't qualify for the special enrollment [More...](#)period, learn what resources are available and when to enroll in the Health Insurance Marketplace. Questions and answers will be discussed at the end of the webinar.

###

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.