Module 4 explains Current Topics (new policies, innovations, and legislation) in the programs administered by the Centers for Medicare & Medicaid Services (CMS). This training module was developed and approved by CMS, the federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of July 2017. The CMS National Training Program provides this as an informational resource for our partners. It’s not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.
There are 4 lessons in this training module:

1. Legislation Update
2. Medicare Updates
3. Marketplace Updates
4. Accessibility Support
Lesson 1 provides information on some current laws of particular interest to our partners and stakeholders, including the following:

- **21\textsuperscript{st} Century Cures Act**
- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
The 21st Century Cures Act—signed into law on Tuesday, December 13, 2016, is legislation intended to promote and fund the acceleration of research into preventing and curing serious illnesses; accelerates drug and medical device development; attempts to address the opioid abuse crisis; and, to improve mental health service delivery. The Act includes a number of provisions that affect Medicare and Medicaid.

**Section 4010. Improving Medicare Local Coverage Determinations (LCDs).** This section requires the Secretary to impose specific requirements on Medicare Administrative Contractors (MACs) when issuing LCDs. Specifically, for each LCD a MAC issues, it’s required to make available, on its website and the Medicare website, specified information at least 45 days in advance of the LCD’s effective date. Such information includes the LCD itself, information as to when and where the proposed LCD was first made public, links to the proposed determination and a response to comments submitted on the proposed determination, a summary of evidence that was considered in developing the LCD and a list of sources of such evidence, and an explanation of the rationale that supports the LCD. This section applies to LCDs that are proposed or revised more than 180 days after enactment.

**Section 4011. Medicare Pharmaceutical and Technology Ombudsman.** This provision requires the Secretary to establish a Medicare Pharmaceutical and Technology Ombudsman to receive and respond to complaints, grievances, and requests regarding coverage, coding, or payment that are from entities that manufacture pharmaceutical, biotechnology, medical device or diagnostic products that are covered under Medicare or for which coverage is being sought.

**Section 4012. Medicare Site-of-Service Price Transparency.** This provision requires the Secretary make available information for CY 2017 and subsequent years regarding an appropriate number of items and services for which payment is made to either a hospital outpatient department or an ambulatory surgical center. The information is to be made available via a searchable website. The legislation specifies that the information that is to be made available for services in each site is the estimated payment amount and the estimated amount of beneficiary liability, which is defined as the amount an individual who doesn’t have coverage under a Medicare supplemental policy would be responsible for. The notice of Medicare benefits under section 1804 is required to include information on the availability of this data. Funding of $6,000,000 is provided.
Delay in authority to terminate contracts for Medicare Advantage (MA) Plans failing to achieve minimum quality ratings through Plan Year 2018

Updating the “Welcome to Medicare” package

Preserving Medicare beneficiary choice under MA beginning in 2019
  • First 3 months each year, those who are MA eligible can change coverage

Allowing people with End-Stage Renal Disease to choose an MA Plan beginning in 2021
  • Organ procurement will be covered by Original Medicare

Sec. 17001. Delay in authority to terminate contracts for Medicare Advantage Plans failing to achieve minimum quality. This section, through the end of plan year 2018, delays the Secretary’s authority to terminate an MA contract based on a plan’s failure to achieve a minimum Star Rating.

Sec. 17003. Updating the Welcome to Medicare package. This section requires the Secretary to update the Welcome to Medicare package to include information about receiving benefits through Original Medicare, MA, and Part D. Within 6 months of the date of enactment, the Secretary is required to solicit stakeholder input on the information included in the Welcome to Medicare package. Changes to the package are required within 12 months after the 6-month request for information period, and the package could be subsequently updated as appropriate.

Sec. 17005. Preservation of Medicare beneficiary choice under Medicare Advantage. Beginning in 2019, this section allows an MA eligible individual, during the first 3 months of any year, to change coverage to receive benefits through the Original Medicare fee-for-service program or an MA Plan, and to elect coverage under Part D. This would also apply to individuals newly eligible for MA mid-year during the first 3 months during such year in which the individual is an MA eligible individual. This continuous open enrollment and disenrollment period during the first 3 months of any year starting in 2019 would apply with respect to a prescription drug plan only in the case of an individual who, previous to such change in enrollment, is enrolled in an MA plan. This section would prohibit unsolicited marketing or marketing materials from being sent to such an eligible individual during the continuous open enrollment and disenrollment period.

Sec. 17006. Allowing End-Stage Renal Disease beneficiaries to choose a Medicare Advantage Plan. This section eliminates the prohibition against individuals with End-Stage Renal Disease (ESRD) enrolling in an MA Plan after they have developed ESRD, effective for plan years beginning on or after January 1, 2021. Also beginning with plan year 2021, it transfers responsibility for the costs of acquiring organs for kidney transplants from MA Plans to the fee-for-service portion of Medicare. Payments to MA Plans will be adjusted to reflect that shift.
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made 3 important changes to how Medicare pays those who give care to people with Medicare.

- **Called the Quality Payment Program (QPP)**
  1. Ends the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers’ services by tying quality to payment
  2. Makes a new framework for rewarding health care providers for giving better care, not just more care
  3. Combines our existing quality reporting programs into one new system

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Public Law No: 114-10). This law contains several provisions designed to strengthen Medicare and the Children’s Health Insurance Program (CHIP). The law repeals the Sustainable Growth Rate (SGR) methodology under the Medicare Physician Fee Schedule and establishes a new Merit-Based Incentive Payment System, extends CHIP, and extends several Medicare and other health care provisions that were set to expire. We’ll go over a section-by-section summary and how it impacts our programs.

The MACRA made 3 important changes to how Medicare pays those who give care to people with Medicare.

1. **Ending the Sustainable Growth Rate (SGR) formula (controlled the growth in aggregate of Medicare expenditures for physicians’ services) for determining Medicare payments for health care providers’ services by tying quality to payment**
2. **Making a new framework for rewarding health care providers for giving better care, not just more care**
3. **Combining our existing quality reporting programs into one new system**

These changes, named the Quality Payment Program (QPP), replace a patchwork system of Medicare reporting programs with a flexible system that permits a selection from 2 paths that link quality to payments—the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs).
Lesson 3 provides information about changes in Medicare, including the following:

- Program Enrollment
- Medicare Access and CHIP Reauthorization Act Medicare Provisions (MACRA)
- Durable Medical Equipment Prosthetic, Orthotic, and Supplies (DMEPOS) Competitive Bidding Round 2019
- Medicare Outpatient Observation Notice (MOON)
- Medicare Advantage (Part C)
- Medicare Prescription Drug Coverage (Part D)
- New Medicare Card
The projected average monthly enrollment numbers are provided in the millions. The totals are rounded.

- In Fiscal Year (FY) 2017, it’s projected that there will be 57.7M people enrolled in Medicare Part A and/or Part B
- Those enrolled in Original Medicare are expected to number 37.7M (for comparison, there were 19.1 million people enrolled in Medicare in 1966)
- Those enrolled in Medicare Advantage (MA) and Other Health plans are expected to number 19.9M, including employer waiver plans
  - 18.3M are enrolled in MA Plans
- Medicare enrollees who have Medicare Part D (Medicare prescription drug coverage), either from their Medicare Advantage Plan or from a Medicare Prescription Drug Plan are expected to number 42.3M

These data are provided by the CMS/Office of Information Products and Data Analytics/Office of the Actuary.
Medicare Access and CHIP Reauthorization Act Medicare Provisions (MACRA)—Updates

- Savings to Medicare and Medicaid Programs
- Income-Related Premium Adjustment for Part B and Part D
- Continuing Automatic Extension of Providers Opt-Out Election
- Medicare Supplement Insurance (Medigap) Policy Changes

- Savings to Medicare and Medicaid Programs
- Income-Related Premium Adjustment for Part B and Part D
- Continuing Automatic Extension of Providers Opt-Out Election
- Medicare Supplement Insurance (Medigap) Policy Changes
The law includes a number of provisions that would result in savings to the Medicare and Medicaid Programs. Beginning in 2018, the income thresholds for determining the premium subsidy for the Medicare Part B and Part D premiums paid by the person with Medicare will change, resulting in more people with Medicare paying the higher premium amounts. In addition, beginning in 2020, more people with Medicare will be subject to income-related premiums due to a change in the indexing of the income thresholds.
Sec. 402—Income-Related Premium Adjustment for Parts B and D

Beginning in 2018, this provision would make adjustments to the current laws’ income-related premium policy. This provision adjusts the amounts of the income thresholds for applying the income-related premium as shown on the above table.

Beginning in 2020, the income thresholds would be adjusted each year by increasing the previous year’s income threshold amounts by the consumer price index for urban consumers (CPI-U).
Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by Section 401 “Limitation on certain Medigap policies for newly eligible Medicare beneficiaries.”

“(1) IN GENERAL—Notwithstanding any other provision of this section, on or after January 1, 2020, a Medicare Supplemental Policy that provides coverage of the Part B deductible, including any such policy (or rider to such a policy) issued under a waiver granted under subsection (p)(6), may not be sold or issued to a newly eligible Medicare beneficiary.

(2) NEWLY ELIGIBLE MEDICARE BENEFICIARY DEFINED—In this subsection, the term ‘newly eligible Medicare beneficiary’ means an individual who is neither of the following:

(A) An individual who has attained age 65 before January 1, 2020.

(B) An individual who was entitled to benefits under Part A pursuant to section 226(b) or 226A, or deemed to be eligible for benefits under section 226(a), before January 1, 2020.

(3) TREATMENT OF WAIVED STATES—In the case of a state described in subsection (p)(6), nothing in this section shall be construed as preventing the state from modifying its alternative simplification program under such subsection so as to eliminate the coverage of the Part B deductible for any medical supplemental policy sold or issued under such program to a newly eligible Medicare beneficiary on or after January 1, 2020.

(4) TREATMENT OF REFERENCES TO CERTAIN POLICIES—In the case of a newly eligible Medicare beneficiary, except as the Secretary may otherwise provide, any reference in this section to a Medicare supplemental policy which has a benefit package classified as ‘C’ or ‘F’ shall be deemed, as of January 1, 2020, to be a reference to a Medicare Supplemental policy which has a benefit package classified as ‘D’ or ‘G’, respectively.

(5) ENFORCEMENT—The penalties described in clause (ii) of subsection (d)(3)(A) shall apply with respect to a violation of paragraph (1) in the same manner as it applies to a violation of clause (i) of such subsection.”
The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act requires hospitals and critical access hospitals (CAHs) to provide written and oral notification to individuals receiving observation services as outpatients for more than 24 hours. The written notice must be delivered no later than 36 hours after observation services are initiated, must include the reason the individual is receiving observation services, and must explain the implications of receiving outpatient observation services, such as cost-sharing, and post-hospitalization eligibility for Medicare coverage of skilled nursing facility (SNF) services. The hospital or Critical Access Hospital (CAH) must obtain the signature of the individual or an individual acting on behalf of the patient. The Medicare Outpatient Observation Notice (MOON) will serve as the standardized notice used to notify persons entitled to Medicare benefits under Title XVIII of the Act, who receive more than 24 hours of observation services that their hospital stay is outpatient and not inpatient, and the implications of being an outpatient.

- Hospitals must issue the MOON to beneficiaries in Original Medicare and MA Plans
- Hospitals began using the MOON by March 8, 2017

This section refers to changes in Medicare Advantage Plans (Part C) and Medicare prescription drug (Part D) coverage.

- **2018 requirements**
  - Medicare Advantage Plans (Part C)
  - Medicare Prescription Drug Plans (Part D)
On Wednesday, November 2, 2016, CMS issued a final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2017. The final rule requires health care providers and suppliers to be screened and enrolled in Medicare to contract with a Medicare Advantage (MA) organization to provide items and services to beneficiaries enrolled in Medicare Advantage health plans. CMS believes this rule is necessary to help ensure that Medicare enrollees receive appropriate or medically-necessary items or services from health care providers and suppliers that fully comply with Medicare enrollment requirements. The Medicare enrollment process helps to protect Medicare beneficiaries and the Medicare Trust Funds by carefully screening health care providers and suppliers, especially those that could pose an elevated risk to Medicare or to beneficiaries, to ensure that they are qualified to furnish Medicare items and services.

Medicare beneficiaries, the Medicare Trust Funds, and the program at large are at risk when providers and suppliers have not been adequately screened and enrolled. We believe our enrollment processes will further ensure that only qualified providers and suppliers treat Medicare beneficiaries. For instance, MA network providers that perform medically unnecessary tests, treatments, or procedures could threaten enrollees’ welfare, as could a physician who routinely overprescribes prescription drugs. Requiring providers and suppliers that contract with an MA organization and furnish items and services to enroll in Medicare allows CMS to provide more robust oversight and conduct consistent verification of information provided by these health care providers and suppliers.

Any time a health care provider or supplier fails to meet CMS enrollment requirements or violates certain federal rules and regulations, CMS may revoke the provider or supplier’s enrollment and prevent them from billing Medicare Part A or Part B Programs and from prescribing Part D drugs. This final rule also prevents MA Plans from making payments to individuals or entities that have been excluded by the Office of Inspector General or have been revoked by the Medicare Program, regardless of if that provider or supplier is out of network.

**Medicare Advantage (Part C) Provider and Supplier Enrollment**

- Health care providers must be enrolled in Medicare to contract with a Medicare Advantage organization
  - Creates consistency with CMS’s current health care provider and supplier enrollment
  - Helps to protect Medicare beneficiaries and the Medicare Trust Funds
  - Ensures that only qualified providers and suppliers treat Medicare beneficiaries
### Medicare Advantage (MA) Service Category Cost-Sharing Requirements

- CMS will not permit cost-sharing for the first 20 days of the Skilled Nursing Facility (SNF) benefit for CY 2018
- The per-day cost-sharing for days 21 through 100 must not be greater than the Original Medicare SNF amount
- Cost-sharing for the overall SNF benefit must be no higher than the actuarially equivalent cost-sharing in Original Medicare
- MA Plans may not charge higher cost-sharing than Medicare for chemotherapy administration, skilled nursing care, and renal dialysis

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**Service Category Cost-Sharing Requirements**

CMS has traditionally afforded Medicare Advantage (MA) Plans greater flexibility in establishing Part A and Part B cost-sharing by adopting a lower, voluntary maximum out-of-pocket (MOOP) limit than is available to plans that adopt a higher, mandatory MOOP limit.

As indicated in the final CY 2017 Call Letter, CMS will not permit cost-sharing for the first 20 days of the SNF benefit for CY 2018. Please note plans aren’t permitted to apply a service category deductible or a per stay amount to the SNF benefit. In CY 2017, MA Plans with a voluntary MOOP were able to have limited cost-sharing for the first 20 days of the SNF benefit. However, total cost-sharing for the overall SNF benefit (days 1-100) was not permitted to be higher than the actuarially equivalent cost-sharing in Original Medicare, pursuant to §1852(a)(1)(B).

Three additional cost-sharing thresholds have been added for 1) cardiac rehabilitation services, 2) intensive cardiac rehabilitation services, and 3) pulmonary rehabilitation services. As indicated in the final CY 2017 Call Letter, these services have been an area of concern for CMS based on research conducted with organizations having higher than expected cost-sharing amounts or benefits designs that were not fully transparent to beneficiaries.

CMS is continuing to conduct research and evaluate additional changes to the service category cost-sharing limits and we expect to add other limits for inpatient acute and inpatient psychiatric days in future years. For example, CMS is considering additional limits for shorter stays for both inpatient acute and inpatient psychiatric applicable in CY 2019 and encourage organizations to take this into consideration as they design their benefit packages for CY 2018.
Medicare out-of-pocket (MOOP) limits are based on a beneficiary-level distribution of Part A and Part B cost-sharing for individuals enrolled in Original Medicare. The mandatory MOOP amount represented approximately the 95\textsuperscript{th} percentile of projected beneficiary out-of-pocket spending. Stated differently, 5 percent of Original Medicare beneficiaries are expected to incur approximately $6,700 or more in Part A and Part B deductibles, copayments, and coinsurance. The voluntary MOOP amount of $3,400 represents approximately the 85\textsuperscript{th} percentile of projected Original Medicare out-of-pocket costs.
CMS reviewed its policies for the optional seamless enrollment mechanism in light of recent inquiries regarding the mechanism, its use by Medicare Advantage (MA) organizations, and the beneficiary protections currently in place. As a result, CMS is temporarily suspending its acceptance of any new seamless enrollment proposals.

CMS has published data on seamless conversion enrollments on the Medicare Managed Care Enrollment and Eligibility webpage found at CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html.

This information identifies the organizations that have received CMS approval to offer seamless enrollment to individuals upon their conversion to Medicare, as outlined in Section 40.1.4 of Chapter 2 of the Medicare Managed Care Manual. The posted information specifies the lines of business from which these organizations are permitted to enroll members into an MA Plan and the MA Plans into which seamless enrollment may occur.

The MA organizations listed in the aforementioned posting are the only organizations currently listed in CMS records as approved to conduct seamless conversion enrollments.
CMS is proposing a number of updates intended to address drug utilization within the Part D program. Allowing Part D plans to designate specific drugs for which a member’s initial fill could be limited to a one-month supply
- After the first one-month supply, the change to extended days’ supply would be continuous for the person with Medicare

Encourages sponsors to inform people with Medicare directly of additional formulary drugs that become available mid-year

The goal is to improve safety and reduce waste.
## Tiering Exceptions: Policy Clarifications

**Preferred and Non-Preferred Drugs**

- Plan should not restrict their consideration of a tiering exception request based on the tier label; and
- Should not limit their consideration to a single lower tier if there are multiple lower tiers containing alternative drugs.

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### Tiering Exceptions: Policy Clarifications

CMS anticipates that the following policy clarifications related to tiering exceptions will make the process more accessible for enrollees and less cumbersome for plan sponsors to administer. By helping plan sponsors ensure that their tiering exceptions process complies with CMS requirements, we also hope that it will help reduce Independent Review Entity (IRE) overturns for these cases.

**Preferred and Non-Preferred Drugs**

When plans design their tiering exceptions criteria and adjudicate requests for tiering exceptions, CMS expects these sponsors to apply the correct definitions for preferred and non-preferred drugs. Pursuant to 42 C.F.R. §423.100, a preferred drug is “a covered Part D drug on a Part D plan's formulary for which beneficiary cost-sharing is lower than for a non-preferred drug in the plan's formulary.” Sponsors should not base tiering exception eligibility on the tier label of the tier on which the alternative drug(s) are placed, but rather whether the tier has lower cost-sharing than the requested drug, thereby making it preferred.

For example, if the plan sponsor’s formulary includes Tier 2: Generic ($15 copay) and Tier 3: Preferred Brand ($45 copay), Tier 2 is preferred relative to Tier 3. In this example, Tier 2 is a mixed tier containing both brand and generic drugs. Outside of the allowable limitations established by CMS (For example, the requested drug is on the specialty tier, there are no alternatives contained on any lower tier), plan sponsors should not restrict their consideration of a tiering exception request based on the tier label, and should not limit their consideration to a single lower tier if there are multiple lower tiers containing alternative drugs.
Specialty Tiers

Per 42 C.F.R. § 423.578 (a)(7), if a Part D plan sponsor maintains a formulary tier (the specialty tier) in which it places very high cost and unique items, such as genomic and biotech products, the sponsor may design its exception process so that very high cost or unique drugs aren't eligible for a tiering exception. Only Part D drugs with sponsor-negotiated prices that exceed an established dollar-per-month threshold are eligible for specialty tier placement. The current cost threshold of $670 was established for CY 2017 as a result of applying the annual percentage increase used in the Part D benefit parameter updates to the previous threshold of $600.

Given that CY 2017 is the first year for the increased specialty tier threshold, CMS is continuing to collect data to support future policy making. Initial analyses have been performed utilizing CY 2016 prescription drug event (PDE) data and the drugs identified as generally being eligible for specialty tier inclusion based on the $670 threshold. CMS will maintain the $670 threshold for CY 2018, but we will continue to investigate these and other trends to shape future analyses involving the specialty tier.
CMS finalized CMS-4159-F Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs (“Final Rule”) on May 23, 2014. On May 6, 2015, CMS published CMS-6107-IFC Medicare Program; Changes to the Requirements for Part D Prescribers, an interim final rule with comment (“IFC”) that made changes to the Final Rule. These regulations are codified at 42 CFR § 423.120(c)(6). We refer to these rules in this memo as the “Part D Prescriber Enrollment Requirement.”

CMS is implementing a multifaceted phased approach to ensure enforcement of the Part D Prescriber Enrollment Requirement by January 1, 2019. While CMS is committed to the implementation of the Part D Prescriber Enrollment Requirement, CMS also recognizes the need to minimize the impact on the beneficiary population and ensure beneficiaries have access to the care they need. To strike this balance, CMS will implement a multifaceted phased approach which will align enforcement of the Part D Prescriber Enrollment Requirement with other CMS initiatives. Full enforcement of the Part D Enrollment Requirement will be January 1, 2019.

With the revised date, CMS will employ additional strategies in the interim to increase prescriber enrollment and identify and eliminate vulnerabilities to strengthen the Medicare Part D program. CMS will provide further guidance on the implementation of the above referenced additional strategies in future guidance. In addition, this delay will provide Part D sponsors and pharmacy benefit managers (PBMs) and Medicare Advantage Organizations (MAOs) offering MA-PDs sufficient time to finalize the system enhancements needed to comply with the Part D Prescriber Enrollment Requirement and various guidance documents released by CMS since publication of the IFC. These various guidance documents are available at CMS.gov/Medicare/ Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Prescriber-EnrollmentInformation.html.
Part D Low Enrollment

- CMS has the authority to non-renew Part D plans that do not have a sufficient number of enrollees.
- Plans that have fewer than 500 enrollees are urged to voluntarily withdraw.
- Stand-alone plans with less than 1,000 enrollees are encouraged to consolidate.

Part D Low Enrollment

CMS has the authority under 42 CFR §423.507(b)(1)(iii) to non-renew Part D plans (at the benefit package level) that don’t have sufficient number of enrollees to establish that they’re viable plan options. While we’re particularly concerned with plans that have fewer than 500 enrollees, we urge sponsors to voluntarily withdraw or consolidate any stand-alone plan with less than 1,000 enrollees. Sponsors are strongly encouraged to view data on plan enrollment at CMS.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAvPartDEnrolData/index.html to determine if any of their plans meet this criterion.

In April 2017, we notified plans with less than 1,000 enrollees of available options for consolidation/withdrawal options. We reserve the right to require low enrollment plans to consolidate/withdraw in the future to ensure that all Part D plans offered are attractive to beneficiaries and don’t add to their confusion in selecting a plan best suited to their prescription drug coverage needs.
If you reach the Medicare Part D coverage gap in 2017, you'll pay 40% of the plan's cost for covered brand-name prescription drugs. You get these savings if you buy your prescriptions at a pharmacy or order them through the mail. The discount will come off of the price that your plan has set with the pharmacy for that specific drug. What the drug plan pays toward the drug cost and what the drug plan pays toward the dispensing fee aren't counted toward your out-of-pocket spending.

In 2017, Medicare will pay 49% of the price for generic drugs during the coverage gap. You'll pay the remaining 51% of the price. What you pay for generic drugs during the coverage gap will decrease each year until it reaches 25% in 2020. The coverage for generic drugs works differently from the discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap.

If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the price of the drug. The discount for brand-name drugs will apply to the remaining amount that you owe.
The Medicare card is changing.
The Health Insurance Claim Number (HICN) is a Medicare beneficiary’s identification number, used for processing claims and for determining eligibility for services across multiple entities (for example, Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers, and health plans).

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 mandates the removal of the Social Security Number (SSN)-based HICN from Medicare cards to address current risk of beneficiary medical identity theft.

The legislation requires that CMS mail out new Medicare cards with a new Medicare Number (also referred to as Medicare Beneficiary Identifier – (MBI)) by April 2019.

The new Medicare numbers won’t change Medicare benefits. People with Medicare may start using their new Medicare cards as soon as they get them.
<table>
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<tr>
<th>CMS will use a number Medicare Beneficiary Identification (MBI) number generator to</th>
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<tbody>
<tr>
<td><strong>1. Generate new, unique Medicare Numbers for all people with Medicare:</strong> Includes existing (currently active, deceased, or archived) and people new-to-Medicare</td>
</tr>
<tr>
<td>- Deceases/archived will get new number for claims cross walk, but no card will be mailed</td>
</tr>
<tr>
<td><strong>2. Issue new, redesigned Medicare cards:</strong> New cards containing the new Medicare Number to existing and new people with Medicare</td>
</tr>
<tr>
<td><strong>3. Modify systems and business processes:</strong> Required updates to accommodate receipt, transmission, display, and processing of the new Medicare Number</td>
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CMS anticipates that the Medicare beneficiary identification number (MBI) will not be changed for an individual unless the MBI is compromised or other limited circumstances still undergoing review.
New cards start mailing in April 2018 and all cards are replaced by April 2019 deadline

- Gender and signature line won’t appear on new Medicare cards
- Once their card is mailed, someone with Medicare also can access their New Medicare Number on a Medicare Summary Notice or through MyMedicare.gov
- The Railroad Retirement Board will issue new cards to RRB beneficiaries
The transition period will run from April 1, 2018 through December 31, 2019. CMS will complete its system and process updates to be ready to accept and return the new Medicare Number on April 1, 2018.

All stakeholders who submit or receive transactions containing the HICN must modify their processes and systems to be ready to submit or exchange the new Medicare Number by April 1, 2018. Stakeholders may submit either the new Number or HICN during the transition period.

CMS will accept, use for processing, and return to stakeholders either the new Medicare Number or HICN, whichever is submitted on the claim, during the transition period.
Medicare Providers must program their systems to identify Railroad Retirement Board (RRB) beneficiaries so they know to send those claims to the Specialty Medicare Administrative Contractor (SMAC).

- Private payers
  - For non-Medicare business, private payers won’t have to use the Medicare beneficiary identification number (MBI). We’ll continue to use supplemental insurer’s unique numbers to identify customers, but after the transition period, supplemental insurers must use the MBI for any Medicare transactions where they would have used the HICN.
In addition, CMS is working to develop capabilities where providers will be able to access a beneficiary’s Medicare beneficiary identification number (MBI) through a secure look-up tool at the point-of-service.

In instances in which a beneficiary does not have a new Medicare card at a provider’s office, we believe this look up tool will give providers a mechanism to access a beneficiary’s MBI securely without disrupting workflow.

CMS is making systems changes so that when a provider checks a beneficiary’s eligibility, the CMS HIPAA Eligibility Transaction System (HETS) will return a message on the response indicating that CMS mailed that particular beneficiary’s new Medicare card.
This is where we really need the help of our trusted and dedicated partners.
In general, reactions were positive

- A good thing to do—protecting identities
- Smart—will keep SSNs out of the hands of criminals
- Helpful—need a new card because old card is worn and frayed
- Long overdue—should have been done some time ago

Some concerns expressed among a minority of participants

- Beneficiaries with Medicare Advantage plans concerned about confusing new Medicare card with MA card
- A few who use their card to reference their SSN or use their Medicare card as an alternate form of identification

These cards are being mailed starting in April to avoid confusion with when Medicare Advantage cards are mailed and we are working with plans.
<table>
<thead>
<tr>
<th>Language to use</th>
<th>Here’s why</th>
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<tbody>
<tr>
<td>The new Medicare card has a new “Medicare Number”</td>
<td>“Medicare Number” resonated best with consumers in testing, who easily understand that “number” can include identifiers that are alpha-numeric. Consumers also understand that an alpha-numeric number is considered more “safe.”</td>
</tr>
<tr>
<td>Medicare is removing Social Security Numbers from Medicare cards</td>
<td>This soft, simple language is well received and easily understood. Consumers prefer “removing” to “taking off,” which implies loss. Without specific reference to removal of Social Security Numbers, people with Medicare are more suspicious of the change, leading to conjecture including “my benefits are changing/decreasing” or “this is a waste of money.”</td>
</tr>
<tr>
<td>Medicare will mail you a new card</td>
<td>This clearly conveys that a new card will arrive by mail, which is more specific than generic words such as “send” or “get.”</td>
</tr>
<tr>
<td>The change will help protect your identity</td>
<td>While most consumers perceive removing Social Security Numbers from Medicare cards as positive, they still want CMS to explain why this is happening. Consumers perceive preventing identify theft to be the primary benefit of and reason for the change and feel it is a good thing to do.</td>
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Read the text in the table.
### Messaging That Works (continued)

<table>
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<tr>
<th>Language to use</th>
<th>Here’s why</th>
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<tr>
<td>&quot;Unique number&quot; or &quot;number that’s unique to you&quot;</td>
<td>Explaining that the number is unique reassures consumers that the new number won’t be duplicated or shared with anyone else. Consumers did not react positively to the phrase &quot;randomly generated number,&quot; as it raised concerns that the number could be given to more than one person, such as when multiple people win the lottery.</td>
</tr>
<tr>
<td>Once you get your new card, destroy your old card and start using your new card right away</td>
<td>Destroying the old card and using the new card immediately is an understood protocol, but consumers appreciate this as good information to reconfirm.</td>
</tr>
<tr>
<td>New card, new number</td>
<td>Helps consumers understand that numbers aren’t simply being removed from the cards; they’re being replaced with the new unique number.</td>
</tr>
<tr>
<td>People with Medicare</td>
<td>Medicare has consistently referred to &quot;beneficiaries&quot; as &quot;People with Medicare&quot; in TV ads and publications for 15 years, and we recommend keeping this language.</td>
</tr>
<tr>
<td>Medicare will be mailing new Medicare cards between April 2018 and April 2019</td>
<td>Including a start and stop date for the receipt of new Medicare cards is important to help set consumer expectations and alleviate concerns if a card doesn’t immediately arrive.</td>
</tr>
<tr>
<td>Protect yourself by making sure no one can get your personal information from your old Medicare card</td>
<td>This is considered good information to re-state and confirms consumer perceptions that preventing theft of their own personal information is the primary advantage of this project.</td>
</tr>
</tbody>
</table>

Read the text in the table.
Other Key Points to Reinforce

- Understand that mailing everyone a new card will take some time. Your card might arrive at a different time than your friend’s or neighbor’s.
- Make sure your mailing address is up-to-date. If your address needs to be corrected, contact Social Security at [ssa.gov/myaccount](http://ssa.gov/myaccount) or 1-800-772-1213. TTY: 1-800-325-0778.
- Beware of anyone who contacts you about your new Medicare card. We will never ask you to give us personal or private information to get your new Medicare number and card.

Other key points to reinforce

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Stay Connected

Find more technical information, detailed updates, training opportunities, and materials to share on the web:
https://www.cms.gov/newcard

Comments and questions are always welcome! Send to:
SSNRemoval@cms.hhs.gov
Lesson 5 provides information about changes to the Health Insurance Marketplace, including the following:

- New Special Enrollment Period Verification (SEPV)
- New Health Coverage Enrollment Option for Small Business
- Proxy Direct Enrollment Pathway for 2018 Individual Market Open Enrollment Period

**NOTE:** There's guidance out about direct enrollment for consumers at [CMS.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-17.html](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-17.html)
Special Enrollment Periods (SEPs) provide a way for people who lose health insurance or experience other qualifying events during the year to enroll in or change coverage outside of the annual open enrollment period.

- In most cases, consumers have 60 days from the date of the qualifying event to enroll in coverage.
Beginning in Summer 2017, new applicants (those who aren't already enrolled in Marketplace coverage) who attest to certain types of SEP qualifying events will be subject to the SEPV process or pre-enrollment verification. Eligible consumers must submit documents that confirm their SEP eligibility before they can enroll and start using their Marketplace coverage.

Phase 1: On June 23, 2017, pre-enrollment verification starts for 2 SEP types:
- Loss of coverage
- Permanent move

Phase 2: In August 2017, pre-enrollment verification starts for 3 additional SEP types:
- Marriage
- Gaining or becoming a dependent through adoption, placement for adoption, placement in foster care, or a child support or other court order
- Medicaid/CHIP denial

For more information, visit https://marketplace.cms.gov/technical-assistance-resources/sep-preenrollment-verification-overview.pdf
CMS will be exploring a more efficient implementation of the Federally-facilitated SHOP Marketplaces in order to promote insurance company and agent/broker participation and make it easier for small employers to offer SHOP plans to their employees, while maintaining access to the Small Business Health Care Tax Credit. CMS intends to propose rulemaking that would change how small employers and employees in SHOPs using HealthCare.gov enroll in SHOP plans taking effect on or after January 1, 2018. Under the approach CMS intends to propose, instead of enrolling online at HealthCare.gov, employers would enroll directly with an insurance company offering SHOP plans, or with the assistance of an agent or broker registered with the Federally-facilitated SHOP. Employers would still obtain a determination of eligibility by going to HealthCare.gov. Employers that have enrolled in SHOP coverage for plan years that began in 2017 would be able to continue using HealthCare.gov in 2018 for enrollment and premium payment, until their current plan year ends and it’s time to renew. Employers can sign up for SHOP coverage taking effect in 2017 on HealthCare.gov until November 15, 2017. States operating State-based SHOP Marketplaces would be able to provide for online enrollment, or could opt to direct small employers to insurance companies and SHOP-registered agents and brokers to directly enroll in SHOP plans.

This past May, CMS announced a new streamlined and simplified direct enrollment process for consumers signing up for individual market coverage through Exchanges that use HealthCare.gov. Consumers applying for individual market coverage during the upcoming open enrollment period through direct enrollment partners will now be able to complete their application using one website. This reduces needless regulatory burden for businesses that provide direct enrollment services and offers consumers easier access to healthcare comparisons and shopping experiences for coverage offered through HealthCare.gov.

In prior years, consumers who signed up for health coverage using a third party website were redirected to HealthCare.gov to complete their application. Consumer feedback showed that the process was confusing and made it harder to finish the application. The new process allows consumers to start and finish their application through the third-party website of direct enrollment partners approved to use the proxy direct enrollment pathway.

The guidance announced today is part of a larger CMS effort intended to stabilize the health insurance market by providing more ways for consumers to access coverage. To read more about the guidance, visit CMS.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-for-the-Proxy-Direct-Enrollment-Pathway-for-2018-Individual-Market-Open-Enrollment-Period.pdf.
This training is provided by the CMS National Training Program (NTP).

To view all available NTP training materials, or to subscribe to our email list, visit [CMS.gov/outreach-and-education/training/CMSNationalTrainingProgram](http://CMS.gov/outreach-and-education/training/CMSNationalTrainingProgram).

Stay connected.
Contact us at training@cms.hhs.gov, or follow us @CMSGov #CMSNTP.