

MOA MEMBERS
FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR
MAY 10, 2010

FRONTIER FOCUS: A REGION VII MEDICARE UPDATE

The following Medicare update is forwarded for your information. You may wish to share the information with your office billing staff.

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## 1. Update on Claims Processing for Ordering/Referring Providers

The Centers for Medicare & Medicaid Services (CMS) will delay until January 3, 2011, the implementation of Phase 2 of Change Request (CR) 6417 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)) and CR 6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

This delay will give physicians and non-physician practitioners who order items or services for Medicare beneficiaries or who refer Medicare beneficiaries to other Medicare providers or suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to Phase 2 implementation.

Although enrolled in Medicare, many physicians and non-physician practitioners who are eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare. A current enrollment record is one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and contains the National Provider Identifier (NPI). Under Phase 2 of the above referenced CRs, a physician or non-physician practitioner who orders or refers and who does not have a current enrollment record that contains the NPI will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected.

CMS continues to urge physicians and non-physician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and non-physician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

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2. CMS Announces Series of Nationwide RAC 101 Calls

Please visit the CMS RAC website at http://www.cms.gov/rac/03_recentupdates.asp for more information.

May 12, 2010 1:00pm - 2:30pm EST: Nationwide RAC 101 Call for Physicians, 1-877-251-0301

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3. Sixth National Education Call on Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 and D.0 Transactions

**Medicare FFS 5010 Program: Taking EDI to the Next Level**

**May 26, 2010**

**2:00pm - 3:30pm EST**

The Centers for Medicare & Medicaid Services (CMS) will host its sixth national education call regarding Medicare FFS's implementation of HIPAA Version 5010 and D.0 transaction standards. This session will focus on the 837 Professional claim transaction. Subject matter experts will review Medicare FFS specific changes as well as general information to help the audience prepare for the transition, which will be followed by a Q&A session. The presentation will be available on the CMS website within 24 hours of the call. To access the presentation, click on the following link and scroll down to the Downloads section:

[http://www.cms.gov/Versions5010andD0/40\\_Educational\\_Resources.asp](http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp)

**Target Audience:** Vendors, clearinghouses, and providers who will need to make Medicare FFS specific changes in compliance with HIPAA version 5010 requirements.

**Registration will close at 2:00 p.m. EST on May 25, 2010 or when available space has been filled.**

**Subject:** Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 837 Professional Claim Transaction

**Agenda:**

- General Overview
- Medicare Specific Changes
- Timelines and Deadlines
- What you need to do to prepare
- Transaction Specific Issues
- Q & A

Conference call details:

Date: May 26, 2010

Conference Title: Sixth National Education Call on Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 and D.0 Transactions

Time: 2:00 p.m. – 3:30 p.m. ET

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation.

Registration will close at 2:00 p.m. ET on May 25, 2010, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call participants need to go to:  
<http://www.eventsvc.com/palmettogba/052610>
2. Fill in all required data.
3. Verify that your time zone is displayed correctly the drop down box.
4. Click "Register".
5. You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. **Note:** Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.
6. If assistance for hearing impaired services is needed the request must be sent to [medicare.ttt@palmettogba.com](mailto:medicare.ttt@palmettogba.com) no later than 3 business day before the event.

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4. Hold the Date For the CMS 2010 ICD-10/5010 National Provider Conference Call

The Centers for Medicare & Medicaid Services (CMS) will host a national provider conference call on "**ICD-10 Implementation in a 5010 Environment**"

When: Tuesday, June 15, 2010

Time: 12:00 p.m. – 2:00 p.m. EST

Target Audience: Medical coders, physician office staff, provider billing staff, health records staff, vendors, educators, system maintainers and all Medicare fee-for-service (FFS) providers

The following topics will be discussed during the presentation:

ICD-10

- ICD-10 implementation for services provided on and after October 1, 2013
- Benefits of ICD-10
- Differences between ICD-10 and ICD-9-CM codes
- Tools for converting codes – General Equivalence Mappings (GEMs)
- Proposal to freeze ICD-9-CM and ICD-10 code updates except for new technologies and diseases

HIPAA Version 5010

- General Overview HIPAA version 5010 and D.0 and who is impacted
- Compliance dates
- Benefits
- 5010 scope versus ICD-10 Scope
- What you need to do to prepare
- Timelines
- Medicare FFS implementation of HIPAA version 5010 and D.0
- Impact on paper claim forms

This toll-free teleconference will include a question and answer session that will give call participants an opportunity to ask questions of CMS subject matter experts.

Registration information for this national provider conference call will be announced soon, so hold the June 15th date now for this informative provider conference call.

Additional information about ICD-10/5010 can be found at <http://www.cms.hhs.gov/ICD10> on the CMS website.

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#### 5. 2010 Physician Quality Reporting Initiative & Electronic Prescribing Incentive Program National Provider Call with Question & Answer Session

The Centers for Medicare & Medicaid Services' (CMS) Provider Communications Group will host a national provider conference call on the 2010 Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing Incentive Program (eRx). This toll-free call will take place from **1:30 p.m. – 3:00 p.m., EDT, on Wednesday, May 12, 2010.**

The PQRI is voluntary quality reporting program that provides an incentive payment to identified individual eligible professionals (EPs), and beginning with the 2010 PQRI, group practices who satisfactorily report data on quality measures for covered Physician

Fee Schedule (PFS) services furnished to Medicare Part B Fee-For-Service (FFS) beneficiaries.

The PQRI was first implemented in 2007 as a result of section 101 of the Tax Relief and Health Care Act of 2006 (TRHCA), and further expanded as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The eRx Incentive Program is an incentive program for eligible professionals initially implemented in 2009 as a result of section 132(b) of the MIPPA. The eRx Incentive Program promotes the adoption and use of eRx systems by individual eligible professionals (and beginning with the 2010 eRx Incentive Program, group practices).

Following a few program announcements and updates, the lines will be opened to allow participants to ask questions of CMS PQRI and eRx subject matter experts.

Educational products are available on the PQRI dedicated web page located at, <http://www.cms.hhs.gov/PQRI>, on the CMS website, in the Educational Resources section, as well as educational products are available on the eRx dedicated web page located at <http://www.cms.hhs.gov/ERxIncentive> on the CMS website. Feel free to download the resources prior to the call so that you may ask questions of the CMS presenters.

Conference call details:

Date: May 12, 2010

Conference Title: Physician Quality Reporting Initiative (PQRI) - National Provider Call

Time: 1:30 p.m. EDT

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation.

Registration will close at 1:30 p.m. EDT on Tuesday, May 11, 2010, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call participants need to go to:  
<http://www.eventsvc.com/palmettogba/051210>
2. Fill in all required data.
3. Verify that your time zone is displayed correctly in the drop down box.
4. Click "Register".

5. You will be taken to the “Thank you for registering” page and will receive a confirmation email shortly thereafter. **Note:** Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

For those of who will be unable to attend, a transcript of the call will be available at least one week after the call at <http://www.cms.hhs.gov/pqri> on the CMS website.

If you require services for the hearing impaired please send an email to:  
[Medicare.TTT@PalmettoGBA.com](mailto:Medicare.TTT@PalmettoGBA.com).

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6. Special Open Door Forum: Medicare Provider & Supplier Enrollment

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Provider & Supplier Enrollment
May 19, 2010
3:00PM – 5:00PM ET
2:00 PM – 4:00 PM CT

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss Medicare provider enrollment issues. During this call, CMS staff will discuss:

- The May 5, 2010 provider enrollment regulation titled, “Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements (CMS-6010-IFC)”
 - Medicare ordering and referring issues, including physician notification
 - Documentation requirements
- Internet-based Provider Enrollment, Chain and Ownership System (PECOS)
 - Physician, non-physician practitioner, provider and supplier organizations
 - Upcoming availability of Internet-based PECOS for DMEPOS suppliers
- Pharmacy accreditation issues
- Advanced diagnostic imaging accreditation
- Provider and supplier reporting responsibilities
- Revalidation efforts

Afterwards, there will be an opportunity for the public to ask questions.

We look forward to your participation.

Open Door Forum Instructions:

Capacity is limited so dial in early. You may begin dialing into this forum as early as 2:45 PM ET.

Dial: 1-800-603-1774

Reference Conference ID 61448973

Thank you.

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## 7. A Health Information Technology Update

Beacon Communities Lead the Charge to Improve Health Outcomes

[Establishing Beacons for Nationwide Advances in Health IT](#)

A Message from Dr. David Blumenthal, National Coordinator for Health Information Technology

May 5, 2010

Healthcare professionals appreciate opportunities to learn from innovative colleagues and communities – to see what really works, to get “boots-on-the-ground” perspectives, to learn best practices, and to use the experience of other leaders to inform how to improve performance more broadly.

The [Beacon Community Cooperative Agreement Program](#), by its very design, was intended to shine a spotlight on health information technology (health IT) innovators, so that we all might learn from them. Yesterday, [Secretary Sebelius awarded \\$220 million to establish 15 Beacon Communities throughout America](#). These community consortia – selected from 130 applicants – have demonstrated leadership in developing advanced health IT solutions to help improve specific health outcomes. They also share a strong conviction in the benefits of health IT as a critical pillar to advance broad and sustainable health system improvement. The average award amount is \$15 million over 36 months.

The Beacon Community awards recognize collaborative community efforts operating at the cutting edge of health IT and health care delivery system innovation. Beacon Communities will implement a range of care delivery innovations building on existing infrastructure of interoperable health IT and standards-based information exchange, in coordination with the Regional Extension Center Program and State Health Information Exchange Program.

In addition, the program will help Beacon Communities plan and develop new initiatives that can ensure the longer-term sustainability of health IT-enabled improvements in health care quality, safety, efficiency, and population health. This includes preparing for future policy changes resulting from enactment of health care reform legislation that will permit providers, states, and regional health care organizations to test new payment methods emphasizing improvements in quality and value.

Like so many other providers who effectively implement health IT, Beacon Communities

will leverage other existing federal programs and resources to promote health information exchange at the community level. These resources include:

- Department of Defense and the Department of Veterans Affairs Virtual Lifetime Electronic Record (VLER) program, which aims to develop a longitudinal electronic health record for all active duty, Guard and Reserve, retired military personnel, and eligible separated Veterans
- Health Resources and Services Administration (HRSA) programs at federally qualified health centers (FQHCs) and Health Center Controlled Networks (HCCNs) to advance the adoption of certified electronic health records and exchange of health information
- Department of Agriculture and Department of Commerce efforts to extend broadband infrastructure

The partnership with applicable VLER, FQHC, and HCCN sites is particularly important to ensure we realize measurable and tangible results in federally funded, military, and private sector health care settings alike.

I would like to acknowledge and praise the many applicants who were not funded today, but whose experience and commitment suggests our nation has an encouraging foundation of health information exchange to build on. An additional \$30.3 million is currently available to fund additional Beacon Community cooperative agreement awards. An announcement to apply will be made in the near future.

Especially, I am particularly pleased by the [diversity among Beacon awardees](#): geographically, they span the continental United States and reach as far as Hawaii; both urban and rural communities are well represented; and targeted program outcomes span some of America’s most pressing health concerns, from reducing medication errors and improving the care of individuals with cardiovascular disease to reducing disparities in access and outcomes for patients with diabetes. Additionally, the programs bring health IT innovation to a variety of underserved populations to address health disparities and improve patient care. The Beacon Communities demonstrate that health IT can bring meaningful change to health care for all Americans — not just the healthiest, wealthiest, or best insured.

I extend my sincere congratulations to our 15 Beacon Communities. Your work inspires me, and I believe that in the coming months, it will inspire and inform America’s medical and health IT communities.

Sincerely,

**David Blumenthal, M.D., M.P.P.**

National Coordinator for Health Information Technology  
U.S. Department of Health & Human Services

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8. CMS Ruling “CMS-1498-R” Regarding Three Medicare Disproportionate Share Hospital (DSH) Issues

The Centers for Medicare & Medicaid Services (CMS) recently published CMS Ruling “CMS-1498-R” pertaining to three Medicare Disproportionate Share Hospital (DSH) issues. Specifically, the Ruling addresses jurisdictionally proper pending appeals and open cost reports on the issues of Medicare non-covered days (such as exhausted benefit days and Medicare secondary payer days), the data matching process for Supplemental Security Income “SSI” fractions, and “labor and delivery” days. The Ruling became effective on April 28, 2010. To view the Ruling, please visit the CMS website at: <http://www.cms.gov/Rulings/downloads/CMS1498R.pdf>. To view the main Rulings page, click here: <http://www.cms.gov/Rulings/CMSR/list.asp>.

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#### 9. Medicare-Certified Home Health Agencies: HHCAHPS Requirements

Have you heard about the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey (HHCAHPS), but need additional information on how to start it? Visit <http://www.homehealthcahps.org> on the internet, to learn all about it.

If you are a very small HHA with less than 60 HHCAHPS eligible patients annually, by June 16, 2010, you will need to submit the Exemption Form by visiting <http://www.homehealthcahps.org> on the internet, with your patient count.

If you have 60 or more HHCAHPS eligible patients annually, then you will need to do a dry run in the third quarter 2010 (July, August, and/or September), and contract with an HHCAHPS survey vendor listed on <http://www.homehealthcahps.org> on the internet.

All Aboard for the HHCAHPS Survey in 2010!

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10. Reminder: Medicare Solicits Nominees For the Advisory Panel On Ambulatory Payment Classification Groups

The Centers for Medicare & Medicaid Services (CMS) is soliciting nominations for individuals to serve on the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) that advises the Secretary, Department of Health and Human Services, and the Administrator, CMS, about the clinical integrity of the APC groups and their associated weights, which are major elements of the Medicare hospital Outpatient Prospective Payment System (OPPS). **Nominations are due to CMS no later than Wednesday, May 26, 2010, 5 p.m. EST.** There will be five vacancies on the Panel as of September 30, 2010.

On November 21, 2000, the Secretary signed the initial Charter establishing the APC Panel. Since its initial chartering, the Secretary has renewed the APC Panel’s Charter four times: on November 1, 2002; on November 1, 2004; effective November 21, 2006; and on November 2, 2008.

The APC Panel may be composed of up to 15 members and a Chair. The following requirements apply to all members of the Panel:

- Must be representatives of Medicare providers subject to payment under the hospital OPPS: hospitals, hospital systems, or other Medicare providers
- Cannot be consultants or independent contractors
- May be self-nominations or nominations submitted by Medicare providers and other interested organizations
- Must send a written statement that s/he is willing to serve as a member of the APC Panel
- Must send a written statement that s/he works for a Medicare provider paid under the hospital OPPS
- Must submit his/her employer's Medicare provider number
- Must have technical expertise to enable them to participate fully in the Panel's work—such expertise encompasses the following:
 - hospital payment systems
 - hospital medical care delivery systems
 - provider billing systems
 - APC groups, Current Procedural Terminology codes, and alpha-numeric Health Care Common Procedure Coding System codes
 - use of, and payment for, drugs, medical devices, and other services in the outpatient setting, as well as other forms of relevant expertise
- Must have a minimum of 5 years experience in their area(s) of expertise
- Must serve on a voluntary basis, without compensation, pursuant to advance written agreement
- Shall be entitled to receive reimbursement for travel expenses and per diem in lieu of subsistence, in accordance with Standard Government Travel Regulations

The Panel is technical in nature, and it shall deal with the following issues:

- Addressing whether procedures within an APC group are similar both clinically and in terms of resource use
- Evaluating APC group weights
- Reviewing the packaging of OPPS services and costs, including the methodology and the impact on APC groups and payment
- Removing procedures from the inpatient list for payment under the OPPS
- Using single and multiple procedure claims data for CMS' determination of APC group weights
- Addressing other technical issues concerning APC group structure

The current APC Panel membership and other information pertaining to the APC Panel, including its Charter, **Federal Register** notices, membership, meeting dates, agenda topics, and meeting reports can be viewed on the CMS Web site at:

http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.

The notice (CMS-1570-N) is available at: <http://edocket.access.gpo.gov/2010/pdf/2010-6789.pdf> .

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11. Notice: Deadline for Withdrawals and Terminations of Reclassifications For FY 2011 is June 18, 2010

In Table 9A in the Addendum to the FY 2011 IPPS proposed rule ([http://www.cms.gov/AcuteInpatientPPS/downloads/FY\\_2011\\_NPRM\\_WI\\_TABLES.zip](http://www.cms.gov/AcuteInpatientPPS/downloads/FY_2011_NPRM_WI_TABLES.zip)), we identified hospitals that have reclassifications effective in FY 2011. Under 42 CFR 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications for reclassification, or terminate an existing 3-year reclassification that would be effective in FY 2011, within 45 days of the publication of CMS's annual notice of proposed rulemaking. The proposed rule was published on May 4, 2010. Therefore, the regulations require that the request for withdrawal or termination must be received by the Medicare Geographic Classification Review Board, by **June 18, 2010** (see proposed rule for process for submitting requests).

We will soon be publishing in the *Federal Register* a supplemental FY 2011 IPPS proposed rule for implementing the provisions of the Affordable Care Act (ACA, Pub. L. 111-148). Wage index values may change somewhat in the supplemental proposed rule due to our application of sections 3137(c), 3141, and 10324(a) of ACA. In addition, as a result of section 3137(c) of ACA, there may be additional hospitals listed as reclassified in Table 9A. At this time, we expect hospitals will have sufficient time between the display or publication of the supplemental FY 2011 IPPS proposed rule in the *Federal Register* and the June 18, 2010 deadline for withdrawals and terminations to evaluate and make determinations regarding their reclassification for the FY 2011 wage index. However, we may reevaluate the deadline for submitting withdrawals and terminations in the supplemental proposed rule if it does not become available early enough to provide sufficient time for hospitals to make these decisions.

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12. Home Health Prospective Payment System (HHPPS) Personal Computer (PC) Pricer Updates

The CY 2008 and CY 2009 Home Health PPS (HH PPS) PC Pricers have been updated with revised logic. The PC Pricers are on the Centers for Medicare & Medicaid Services (CMS) web page at http://www.cms.hhs.gov/PCPricer/05_HH.asp, under the Downloads section. If you use the CY 2008 or CY 2009 HH PPS PC Pricers, please go to the page above and download the latest version of the PC Pricer posted on 4/30/10.

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13. New from the Medicare Learning Network

REVISED: Special Edition MLN Matters Article #SE1008 – Medicare Coverage of Blood Glucose Monitors and Testing Supplies

The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters Article #SE1008*, “Medicare Coverage of Blood Glucose Monitors and Testing Supplies,” to include additional information regarding special blood glucose monitors for patients with manual dexterity issues, and to clarify certain information regarding the content of orders and when new orders are needed. The article is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1008.pdf> on the CMS website.

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***NEW: Special Edition MLN Matters Article #SE1014 - Medicare Policy Regarding Pressure Reducing Support Surfaces***

The Centers for Medicare & Medicaid Services (CMS) has released a Special Edition *MLN Matters* article to clarify existing support surface medical policies and coverage requirements. The article, SE1014, “Medicare Policy Regarding Pressure Reducing Support Surfaces,” reinforces existing policy and does not present any new policy. It is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1014.pdf> on the CMS website.

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14. May 9-15 is National Women’s Health Week and May 9 Is Mother’s Day!

In the spirit of Mother’s Day and National Women’s Health week, the Centers for Medicare & Medicaid Services asks providers to help keep women with Medicare healthy by encouraging them to take advantage of Medicare-covered Preventive Services.

Medicare covers a wide range of preventive services that can help women with Medicare live longer, healthier lives.

The preventive services Medicare covers for eligible beneficiaries include:

- Screening Mammograms,
- Bone Mass Measurements,
- Screening Pap Tests, and
- Screening Pelvic Exams.

For More Information

- CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for Medicare-covered Preventive Services.
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** ~ This comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare. http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

- **Quick Reference Information: Medicare Preventive Services** ~ This chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy-to-use quick-reference format.
http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **The Bone Mass Measurements Brochure** ~ This brochure provides coverage, coding, and billing information on Medicare-covered bone mass measurements.
http://www.cms.gov/MLNProducts/downloads/bone_mass.pdf
- **The Bone Cancer Screenings Brochure** ~ This brochure provides coverage, coding, and billing information on Medicare-covered cancer screenings, including screening mammographies, pap tests, and pelvic exams.
http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf
- **The Medicare Preventive Services Series: Part 3 Web-Based Training Course (WBT)** ~ This WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, pap tests, pelvic exams, and bone mass measurements. To access the WBT, please visit the MLN homepage at: <http://www.cms.gov/mlngeninfo> Scroll down to “Related Links Inside CMS” and click on “WBT Modules”
- **The Medicare Learning Network (MLN) Preventive Services Educational Products Web Page** ~ provides descriptions and ordering information for Medicare Learning Network (MLN) preventive services educational products and resources for health care professionals and their staff.
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- To order hard copies of certain MLN products, including brochures and the Quick Reference Information chart, please visit the MLN homepage at: <http://www.cms.gov/mlngeninfo> Scroll down to “Related Links Inside CMS” and click on “MLN Product Ordering Page”
- For more information about National Women’s Health Week, please visit the Office on Women’s Health website at: <http://www.womenshealth.gov/whw>

Thank you for helping CMS improve the health of women with Medicare by joining in the effort to educate eligible beneficiaries about the importance of taking advantage of Medicare-covered Preventive Services.

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15. A new "twist" in the law makes it easier to save on your prescription drug costs.

<http://www.ssa.gov/prescriptionhelp/>

Under a new law, more Medicare beneficiaries could qualify for Extra Help with their Medicare prescription drug plan costs because some things no longer count as income and resources. The Extra Help is estimated to be worth an average of \$3,900 per year. To qualify for the Extra Help, a person must be on Medicare, have limited income and resources, and reside in one of the 50 states or the District of Columbia.

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