



MEDICARE SECONDARY PAYER



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The Medicare Secondary Payer (MSP) provisions protect the Medicare Trust Fund. This booklet gives an overview of the MSP provisions and explains your responsibilities.

WHAT IS MSP?

MSP provisions prevent Medicare from paying for items and services when other health insurance coverage is primary. In these cases, the MSP program contributes to the following:

- **National program savings:** The Centers for Medicare & Medicaid Services (CMS) enforcement of MSP provisions saved the Medicare Program approximately \$8.5 billion in Fiscal Year (FY) 2018.
- **Increased provider, physician, and other supplier revenue:** Billing a primary plan before Medicare may provide you with better reimbursement rates. Also, coordinated health coverage may expedite the payment process and reduce administrative costs.
- **Avoidance of Medicare recovery efforts:** Filing claims correctly the first time prevents future Medicare recovery efforts on claims.

Stay Up to Date

To sign up for automatic updates, enter your email address in the “Receive Email Updates” box at the bottom of the [Coordination of Benefits & Recovery \(COB&R\) Overview](#) webpage.

To receive these benefits it is important to ask and/or access accurate, up-to-date information about your Medicare beneficiary’s health insurance coverage. Medicare regulations require providers who submit Medicare claims to determine whether Medicare is the primary payer or secondary payer for items or services furnished to a beneficiary.

WHEN DOES MEDICARE PAY FIRST?

Primary payers must pay a claim first. Medicare pays first for beneficiaries in the absence of other primary insurance or coverage. Medicare may also pay first when the beneficiary has other insurance coverage.

Table 1 lists some common situations when a beneficiary has both Medicare and other health plan coverage and which entity pays first (primary payer) and which entity pays second (secondary payer).

Table 1. Analysis of Common MSP Coverage Situations

Individual	Condition	Pays First	Pays Second
Is 65 or older, and covered by a Group Health Plan (GHP*) through current employment or spouse’s current employment	The individual is entitled to Medicare. The employer has less than 20 employees.	 Medicare	 GHP
Is 65 or older, and covered by a GHP through current employment or spouse’s current employment	The individual is entitled to Medicare. The employer has 20 or more employees or is part of a multiple or multi-employer group with at least one employer employing 20 or more individuals.	 GHP	 Medicare
Is 65 or older, has an employer retirement GHP, and is not working	The individual is entitled to Medicare.	 Medicare	 Retiree Coverage
Is under 65, disabled, and covered by a GHP through their current employment or through a family member’s current employment	The individual is entitled to Medicare. The employer has less than 100 employees.	 Medicare	 GHP
Is under 65, disabled, and covered by a GHP through their current employment or through a family member’s current employment	The individual is entitled to Medicare. The employer has 100 or more employees or is part of a multiple or multi-employer group with at least one employer employing 100 or more individuals.	 GHP	 Medicare

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Has End-Stage Renal Disease (ESRD) and GHP coverage was the primary plan prior to the individual becoming eligible and entitled to Medicare based on ESRD	First 30 months of Medicare eligibility or entitlement.	 GHP	 Medicare
Has ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement.	 Medicare	 GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage prior to becoming eligible or entitled to Medicare	First 30 months of Medicare eligibility or entitlement.	 COBRA	 Medicare
Has ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement.	 Medicare	 COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury	The individual is entitled to Medicare.	WC pays first for health care items or services related to job-related illness or injury. See When May Medicare Make a Conditional Payment? section.  Workers' Compensation	 Medicare

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
<p>Was in an accident or other incident where no-fault or liability insurance is involved</p>	<p>The individual is entitled to Medicare.</p>	<p>No-fault or liability insurance pays first for accident- or other incident-related health care services. See When May Medicare Make a Conditional Payment? section.</p> <p>WC, Liability, or No-Fault pays first when ongoing responsibility for medicals (ORM) is reported. Medicare does not make a payment.</p>	<div style="text-align: center;">  <p>Medicare</p> </div> <p>NOTE: For ORM, Medicare does not make a payment until ORM funds are exhausted.</p>
<p>Is 65 or older, or is disabled and covered by Medicare and COBRA</p>	<p>The individual is entitled to Medicare.</p>	<div style="text-align: center;">  <p>Medicare</p> </div>	<div style="text-align: center;">  <p>COBRA</p> </div>
<p>Dual eligible beneficiary regardless of reason for eligibility</p>	<p>The individual is entitled to both Medicare and Medicaid.</p>	<div style="text-align: center;">  <p>Medicare</p> </div>	<div style="text-align: center;">  <p>Medicaid</p> </div>

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Covered by Medicare and has a Medigap or Medicare supplemental plan	The individual is entitled to Medicare.	 Medicare	 Medigap/Medicare Supplemental Plan
Active duty status military member	The individual is entitled to Medicare and TRICARE.	 TRICARE	 Medicare
Inactive status military member treated by civilian providers	The individual is entitled to Medicare and TRICARE.	 Medicare	 TRICARE
Inactive status military member treated at a military hospital or by other Federal providers	The individual is entitled to Medicare and TRICARE.	 TRICARE	 Medicare

* A GHP is any arrangement of, or contribution from, one or more employers or employee organizations to provide insurance to current or former employees or their families.

For more education on how Medicare works with other government payers, take the [Medicare Learning Network® \(MLN\) Web-Based Training](#) course “Medicare Secondary Payer Provisions.”

ARE THERE EXCEPTIONS TO THE MSP PROVISIONS?

There are no exceptions to the MSP provisions. Federal law ([Social Security Act \(SSA\) § 1862\(b\)](#)) establishes the payment order and takes precedence over State laws and private contracts. Medicare cannot make payment if payment has been already made, or can reasonably be expected to be made by another payer. Even if an entity believes it is the secondary payer to Medicare, due to State law or the contents of an insurance policy, the MSP provisions apply when billing for services.

WHAT HAPPENS IF THE PRIMARY PAYER DENIES A CLAIM?

In the following situations, Medicare **may** make payment, assuming the service is Medicare-covered and payable and the provider files a proper claim:

- A no-fault or liability insurer does not pay during the “paid promptly” period or denies the medical bill
- A WC program does not pay during the “paid promptly” period or denies payment (for example, when WC excludes a medical condition or certain services)
- The beneficiary received services not directly related to the condition for which he or she is receiving WC benefits
- Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) or the ORM benefits terminate or exhaust
- A GHP denies payment for services because:
 1. The beneficiary exhausted plan benefits for certain services
 2. The beneficiary is not entitled to benefits under the GHP
 3. The beneficiary needs services not covered by the GHP

When submitting a primary claim to Medicare, include information identifying why the other payer denied the claim, made an exhausted benefits determination, or another reason that may apply.



WHEN MAY MEDICARE MAKE A CONDITIONAL PAYMENT?

Frequently, there is a long delay between an injury and the decision by the primary payer in a contested compensation case. Medicare may make conditional payments on a pending case to avoid imposing a financial hardship on you and the beneficiary while awaiting a decision in a contested case.

Medicare can make conditional payments on behalf of beneficiaries for Medicare-covered services even if it is not the primary payer. Medicare may make conditional payments for covered services in liability (including self-insurance), no-fault, and WC situations, **if both the following are true:**

- Liability (including self-insurance), no-fault, or WC insurer is responsible for payment
- The claim is not expected to be **paid promptly**

Medicare has the right to recover any conditional payments. The Benefits Coordination & Recovery Center (BCRC) recovers conditional payments from the Medicare beneficiary or their attorney when the beneficiary gets a settlement, judgment, award, or other payment.

Medicare may pay conditional primary benefits if the provider, physician, supplier, or beneficiary fail to file a proper claim with the GHP (or Large Group Health Plan [LGHP]) due to physical or mental incapacity of the beneficiary.

If there is a primary GHP and the provider does not bill the GHP first, Medicare may not pay conditionally on the liability (including self-insurance), no-fault, or WC claim. Providers must bill the GHP before billing Medicare, and the primary payer payment information that appears on all primary payer remittance advices **must appear on the claim submitted to Medicare**. Medicare will not pay conditional primary benefits in other situations where:

- The GHP says it is secondary to Medicare
- The GHP limits its payment when the individual is entitled to Medicare
- The GHP covers the services for younger employees and spouses, but not for employees and spouses age 65 and older
- The GHP says it is secondary to liability, no-fault, or WC insurance

Additionally, Medicare will not make conditional payments associated with WCMSAs or when the ORM exists.

“Paid Promptly” Definition

For no-fault insurance and WC claims, “paid promptly” means payment within 120 days after the no-fault insurance or WC carrier got the claim for specific items and services. Without contradicting information, the date of service for specific items and services must be treated as the claim date when determining the “paid promptly” period; for inpatient services, the date of discharge must be treated as the date of service.

For liability insurance (including self-insurance), “paid promptly” means payment within 120 days after whichever of the following occurs first:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement
- The date the service was furnished or, in the case of inpatient services, the date of discharge

For more information on conditional payments, refer to the following sections of the [Medicare Secondary Payer Manual](#):

- Chapter 1, Section 10.7
- Chapter 3, Sections 30 and 40
- Chapter 5, Section 40
- Chapter 6, Sections 40.3 and 60

A Non-Group Health Plan (NGHP) is coverage from a liability insurer (including self-insurance), no-fault insurer, and WC carrier. Submit all NGHP claims to the appropriate NGHP insurer before submitting to Medicare. For more information and instructions on submitting a claim for conditional payment, refer to the MLN Matters® article on [Clarification of Medicare Conditional Payment Policy](#).

Ongoing Responsibility for Medicals (ORM)

Medicare cannot make payment when payment “has been made, or can reasonably be expected to be made” under liability insurance (including self-insurance), no-fault insurance, or a WC law or plan, also referred to as a primary plan.

When a primary plan reports the existence of ORM to Medicare, it assumes responsibility to pay, on an ongoing basis, for certain medical care related to the accident or injury. Medicare cannot make payment related to this injury without documentation that the ORM has terminated or is otherwise exhausted.

HOW IS BENEFICIARY HEALTH INSURANCE OR COVERAGE INFORMATION COLLECTED AND COORDINATED?

Coordination of Benefits (COB) allows plans that cover Medicare beneficiaries to determine their payment responsibilities. The BCRC collects, manages, and uploads information to the Common Working File (CWF) about Medicare beneficiaries’ other health insurance coverage. **Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the BCRC to coordinate the information.**

BCRC relies on health insurance maintained by stakeholders, including Federal and State Programs; plans that offer health insurance, prescription coverage, or both; pharmacy networks; and a variety of assistance programs. Some of the reporting methods for Medicare to obtain MSP and COB information includes:

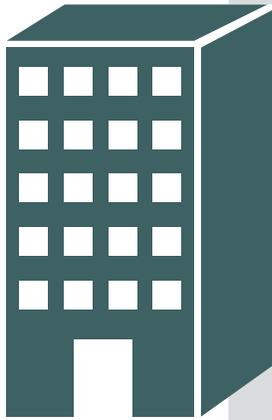
- **Voluntary Data Sharing Agreement (VDSA):** The VDSA allows CMS and an employer to electronically exchange GHP eligibility and Medicare information. The VDSA includes Medicare Part D information, enabling VDSA partners to submit primary or secondary records with prescription drug coverage to Part D.
- **MSP Mandatory Reporting Process:** There are mandatory MSP reporting requirements for GHP and NGHP insurance arrangements, including liability insurance (including self-insurance), no-fault insurance, and WC to report beneficiary MSP information. For more information, refer to [Mandatory Insurer Reporting for GHPs](#) or [Mandatory Insurer Reporting for NGHPs](#).
- **MSP Claims Investigation:** The BCRC investigates when it learns another insurance plan may have primary responsibility for paying the beneficiary's Medicare claims. The BCRC determines if information is missing from MSP records or MSP cases. Single-source investigations offer a centralized location for MSP-related inquiries. Investigations involve collecting data on other health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources, such as correspondence, accident and injury cases, or phone calls.
- **Electronic Correspondence Referral System (ECRS):** ECRS is a web-based application that allows Medicare contractor representatives and CMS Regional Office MSP staff to electronically transmit MSP information to the BCRC.

For more information on the BCRC, refer to the [Medicare Secondary Payer Manual, Chapter 4](#).



WHAT ARE YOUR RESPONSIBILITIES UNDER THE MSP PROVISIONS?

Part A Institutional Providers (Hospitals)



Using the MSP Questionnaire during the admission process, gather accurate MSP data to determine if Medicare is the primary payer by asking Medicare beneficiaries, or their representatives.



Bill the primary payer before billing Medicare.



Submit any MSP information on your Medicare claim using proper payment information, value codes, condition and occurrence codes, etc. (If submitting an electronic claim, include the necessary fields, loops, and segments for Medicare MSP claims processing.)

Part B Providers (Physicians, Practitioners, and Suppliers)



Gather accurate MSP data to determine if Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for MSP information.



Bill the primary payer before billing Medicare.



Submit an Explanation of Benefits (EOB), or remittance advice, from the primary payer with your Medicare claim, with all appropriate MSP information. (If submitting an electronic claim, include the necessary fields, loops, and segments for Medicare MSP claims processing.)

Medicare timely filing requirements apply for Medicare-covered services. For more information, refer to the [Medicare Claims Processing Manual, Chapter 1, Section 70](#).

HOW DO YOU GATHER ACCURATE MSP DATA FROM THE BENEFICIARY?

As a Medicare provider, you must determine whether Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter before submitting a Medicare claim. You can do this by asking Medicare beneficiaries about other coverage. The questions you ask help update the beneficiary insurance information and verify that the beneficiary's record, found in the CWF, is correct and up to date.

CMS developed tools, including an MSP model questionnaire, [Admissions Questions to Ask Medicare Beneficiaries](#), to help providers identify the correct primary claims payers for all beneficiary-furnished services in a hospital. Additionally, there are CMS electronic tools that help identify and verify MSP situations. Refer to the MSP Questionnaire and the various CMS electronic tools in the [Medicare Secondary Payer Manual, Chapter 3](#), Section 20. Your Medicare Administrative Contractor (MAC) may also offer questionnaire tools. For more information, refer to the [Contact your MAC](#) webpage.

Providers are required to retain copies of completed MSP Questionnaires and other MSP information for 10 years after the date of service. You may keep hard copy files, optical images, microfilms, or microfiches. When storing these files online, keep both negative and positive responses to questions.

BCRC Claims Investigation

If you do not give Medicare records of other health insurance or coverage that may be primary to Medicare on any claim and there is an indication of possible MSP considerations, the BCRC may request the beneficiary, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire. The BCRC may send an SCD Questionnaire when:

- The MAC receives a claim with an EOB or remittance advice attached from an insurer other than Medicare
- The MAC receives an electronic claim with other insurance payment information in the appropriate loops and segments
- The beneficiary self-reports or beneficiary's attorney identifies an MSP situation
- The third-party payer submitted MSP information to a MAC or the BCRC

For more information on Secondary Claim Development, refer to CMS' [Reporting Other Health Insurance](#) webpage.

WHAT HAPPENS IF YOU SUBMIT A CLAIM TO YOUR MAC WITHOUT ADDING THE OTHER INSURER'S INFORMATION?

Medicare may mistakenly pay a claim as primary if it meets all billing requirements, including coverage and medical necessity guidelines. However, if the beneficiary's MSP record in the CWF shows another insurer should have paid primary to Medicare, Medicare denies the claim.

If the MAC does not have enough information on the claim or correspondence, it may forward the information to the BCRC, and the BCRC may send the beneficiary, employer, insurer, or an attorney the SCD Questionnaire for additional information. The BCRC reviews the response information on the questionnaire and takes appropriate action.

For more information on proper MSP billing, refer to the [Medicare Secondary Payer Manual, Chapter 3](#).

WHAT HAPPENS IF YOU FAIL TO FILE CORRECT AND ACCURATE CLAIMS?

File proper and timely claims with the appropriate primary payer. Not filing proper and timely claims with the appropriate primary payer may result in claim denial by that payer. Policies vary depending on the payer; check with the payer to learn about its specific policies.

Federal law allows Medicare to recover improper payments. Medicare requires the return of any payment made in error as the primary payer. Generally, for MSP GHP situations, Medicare recovers mistaken payments. Medicare can also fine providers, physicians, and other suppliers for knowingly, willfully, and repeatedly giving inaccurate health insurance information.



WHO DO YOU CONTACT WITH MSP QUESTIONS?

Table 2 gives information about who to contact for specific MSP related questions or situations.

Table 2. Who to Contact for MSP Questions

Contact	Question
<p>BCRC Customer Service Representatives</p> <p>Monday through Friday (except holidays)</p> <p>8 am to 8 pm, ET</p> <p>Toll free lines: 1-855-798-2627</p> <p>Text Telephone (TTY) or Telecommunication Device for the Deaf (TDD) 1-855-797-2627 for the hearing and speech impaired</p>	<ul style="list-style-type: none"> • Questions about Medicare development letters and questionnaires • Report a beneficiary’s accident/injury • Report changes to a beneficiary’s employment or health insurance coverage • Report potential MSP situations • Verify Medicare’s primary/secondary status • Contact Medicare’s Commercial Recovery Center (CRC) <p>For guidance on reporting changes to a beneficiary’s health coverage, refer to the MLN Matters article on Updating Beneficiary Information.</p> <p>Request MSP information from the beneficiary before billing. To protect the rights and information of our beneficiaries, the BCRC cannot disclose this information.</p>
<p>MAC</p> <p>Find your MAC’s website at http://go.cms.gov/MAC-website-list.</p>	<ul style="list-style-type: none"> • Questions about Medicare claim or service denials and adjustments • Questions about how to bill • Questions about the processing of a specific claim • Returning inappropriate Medicare payments • Voluntary refunds

For information about specific mailing addresses within the BCRC and CRC, refer to the [BCRC contacts](#) webpage.

The CRC is responsible for GHP recoveries and handles activities related to recovering those improper payments. BCRC is responsible for liability, no-fault, and WC recoveries. The CRC and BCRC manage all Coordination of Benefits & Recovery (COB&R) activities with two exceptions:

- Recovery demand letters issued by the MSP Recovery Auditors under the demonstration authorized by the Medicare Modernization Act of 2003
- MSP recovery demand letters issued by MACs to providers, physicians, and other suppliers

RESOURCES

Table 3. Resources

Resource	Website
CMS MSP Website	CMS.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer
Medicare & Other Health Benefits: Your Guide to Who Pays First	Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf
MLN Matters® Article SE1217 Guidance for Correct Claims Submission When Secondary Payers Are Involved	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1217.pdf
MLN Matters Article SE17018 Billing in Medicare Secondary Payer (MSP) Liability Insurance Situations	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17018.pdf

Table 4. Hyperlink Table

Embedded Hyperlink	Complete URL
Coordination of Benefits & Recovery (COB&R) Overview	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview
Medicare Learning Network® (MLN) Web-Based Training	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining
Social Security Act (SSA) § 1862(b)	https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
Medicare Secondary Payer Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017
Clarification of Medicare Conditional Payment Policy	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf

Table 4. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Mandatory Insurer Reporting for GHPs	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview
Mandatory Insurer Reporting for NGHPs	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview
Medicare Secondary Payer Manual, Chapter 4	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c04.pdf
Medicare Claims Processing Manual, Chapter 1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
Admission Questions to Ask Medicare Beneficiaries	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf#page=16
Medicare Secondary Payer Manual, Chapter 3	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf
Contact Your MAC	http://go.cms.gov/MAC-website-list
Reporting Other Health Insurance	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Reporting-Other-GHP-Insurance/Reporting-Other-Health-Insurance
Updating Beneficiary Information	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf
BCRC Contacts	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page

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