2023 KAOM Annual Convention

CMS Updates

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Disclaimer

This information is current at the time of presentation but Medicare and Medicaid policy is subject to change. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law. This communication was printed, published, or produced and disseminated at U.S. tax payer expense.

This publication is a general summary that explains certain aspects of the Medicare, Medicaid/CHIP, and Marketplace Programs, but is not a legal document. The official Program provisions are contained in the relevant laws, regulations, and rulings. The Centers for Medicare & Medicaid Services policy changes frequently, and links to the source documents have been provided within the document for your reference.

CMS Strategic Pillars

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

https://www.cms.gov/cms-strategic-plan

https://www.cms.gov/sites/default/files/2022-04/13_CCI%20Fact_sheet_4_12%20Final-508.pdf

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Strategic Pillar: Health Equity

CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.

CMS is working to advance health equity in three critical ways:

- Designing, implementing, and operationalizing policies and programs that support the health of all the people CMS serves.
- Eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved.
- Providing the care and support that our enrollees need to thrive.

https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf

PILLAR:
HEALTH EQUITY

CMS Framework for Health Equity

- Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data
- Priority 2: Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps
- Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
- Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services
- Priority 5: Increase All Forms of Accessibility to Health Care Services & Coverage

https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity

Equity in Rural Health

https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/rural-health

- CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities

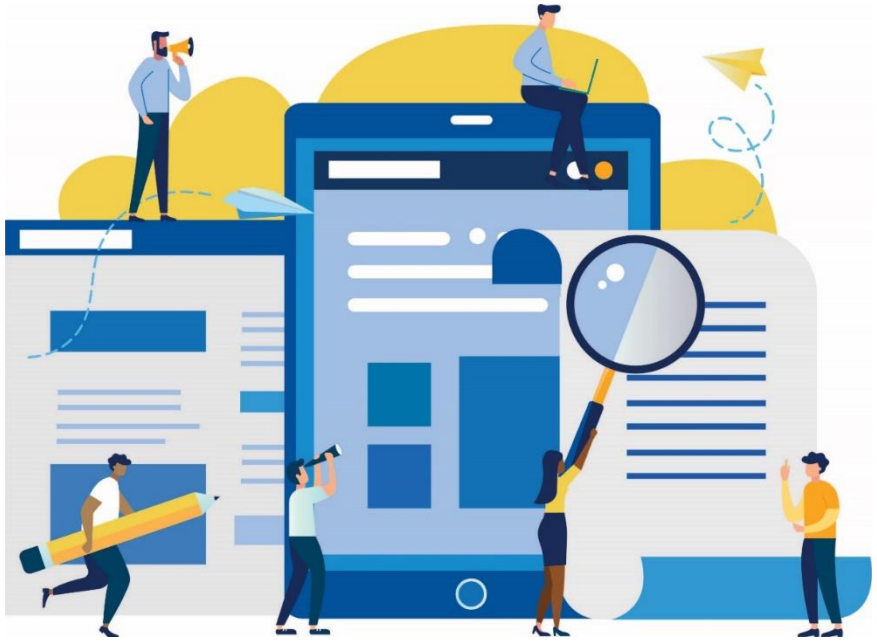
  https://www.cms.gov/files/document/cms-geographic-framework.pdf

  - Priority 1: Apply a Community-Informed Geographic Lens to CMS Programs and Policies
  - Priority 2: Increase Collection and Use of Standardized Data to Improve Health Care for Rural, Tribal, and Geographically Isolated Communities
  - Priority 3: Strengthen and Support Health Care Professionals in Rural, Tribal, and Geographically Isolated Communities
  - Priority 4: Optimize Medical and Communication Technology for Rural, Tribal, and Geographically Isolated Communities
  - Priority 5: Expand Access to Comprehensive Health Care Coverage, Benefits, and Services and Supports for Individuals in Rural, Tribal, and Geographically Isolated Communities
  - Priority 6: Drive Innovation and Value-Based Care in Rural, Tribal, and Geographically Isolated Communities
- Maternal Health Care in Rural Communities

  https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/rural-maternal-health
- Rural Health Resources

  https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/rural-health/rural-health-resources

CMS Health Equity Technical Assistance Program



HealthEquityTA@cms.hhs.gov
https://go.cms.gov/healthequityTA

The CMS OMH Health Equity Technical Assistance program supports quality improvement partners, providers, and other CMS stakeholders by offering:

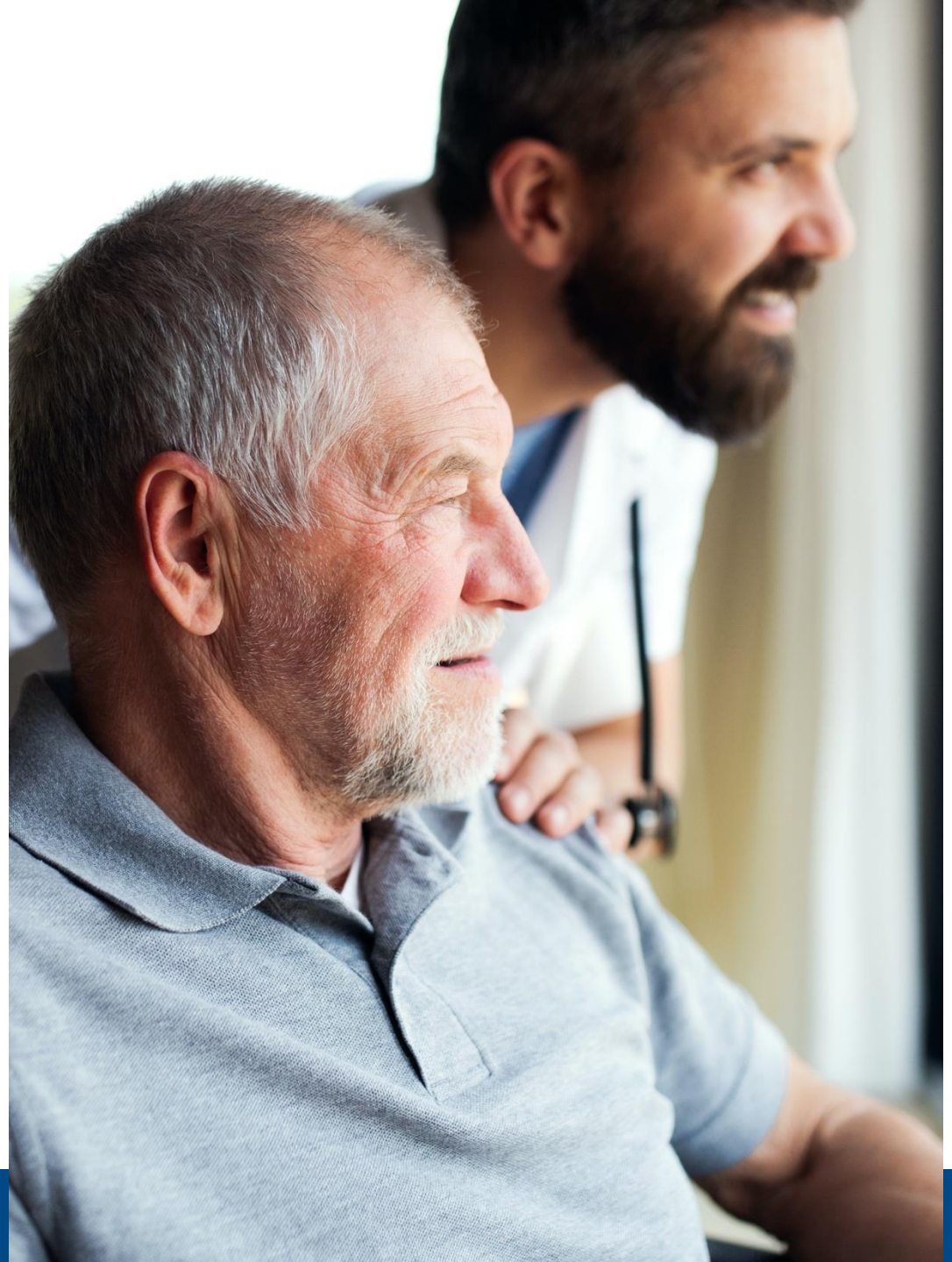
- Personalized coaching and resources
- Guidance on data collection and analysis
- Assistance to develop a language access plan and disparities impact statement
- Resources on culturally and linguistically tailored care and communication

Cross-Cutting Initiatives

- Elevating stakeholder voices through active engagement
- Behavioral health
- Drug price affordability
- Maternity care
- Benefit Expansion
- Rural health
- Preparing the health care system for the post-pandemic world

Cross-Cutting Initiatives (cont.)

- Coverage transition (COVID-19/PHE Unwinding)
- National quality strategy
- Nursing homes and choice in long term care
- Data to drive decision-making
- Integrating the 3M’s (Medicare, Medicaid & CHIP, Marketplace)
- Future of work @ CMS



Coverage to Care (C2C)

What is C2C?

C2C aims to help individuals understand their health coverage and connect to primary care and the preventive services that are right for them, so they can live a long and healthy life.

https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/c2c

C2C Resources

- Examples:
  - Roadmap to Better Care
  - Roadmap to Behavioral Health
  - Connected Care: Chronic Care Management Resources
- Resources are available in English, Arabic, Chinese, Haitian Creole, Korean, Russian, Spanish, and Vietnamese. Ukrainian versions for select resources are available.
- Resources for Tribal Audiences are also available.
- Order printed copies and have them shipped at no cost to your organization or directly to you from the CMS product warehouse. https://productordering.cms.hhs.gov

Inflation Reduction Act (IRA) Medicare Provisions

- Lowering Drug Prices in Medicare through Drug Price Negotiation
- Medicare Part B and Part D Drug Inflation Rebates
- Part D Improvements and Maximum Out-of-Pocket Cap for Medicare Beneficiaries
- Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices Under Medicare Part D
- Expanding Eligibility for Low-Income Subsidies Under Part D of The Medicare Program

Inflation Reduction Act Medicare Provisions (continued)

- Improving Access to Adult Vaccines Under Medicaid and CHIP
- Appropriate Cost-Sharing for Covered Insulin Products Under Medicare Part D
- Limitation on Monthly Coinsurance and No Application of Deductible Under Medicare Part B for Insulin
- Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers

Lowering Prices Through Drug Price Negotiation: Part B & Part D

- Requires the Secretary to establish a Drug Price Negotiation Program for negotiating (and re-negotiating) drug prices of certain Medicare drugs with drug manufacturers
- Establish “maximum fair prices” negotiated for certain Medicare Part B and Part D drugs selected for negotiation
- Negotiated maximum fair prices for the first 10 Medicare Part D drugs selected for negotiation will apply beginning with 2026

Insulin Paid for by Medicare Part B

If you take insulin through a traditional pump that is covered under Medicare's DME benefit, that insulin is covered under Medicare Part B—these benefits go into effect on July 1, 2023

- Insulin is capped at $35 for a one-month supply of insulin
- No deductible will be applied to Part B-covered insulin

NOTE: if you use a **disposable** pump, the insulin for that pump is covered under Medicare Part D and is included in the benefit that starts on January 1, 2023.

Appropriate Cost-Sharing for Covered Insulin Products Under Medicare Part D

- Requires Part D sponsors to eliminate the deductible with respect to insulin products
- Limits beneficiary cost-sharing for covered Part D insulin products to no more than $35 for a month's supply
- If the beneficiary gets a 60- or 90-day supply of insulin, their costs can't be more than $35 for each month's supply of each covered insulin
- **Effective Date**: January 1, 2023
- Part D plans are required to reimburse an enrollee within 30 days for any cost-sharing paid by such enrollee that exceeds the capped cost-sharing amount for any covered insulin product dispensed between January 1 and March 31, 2023

Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices (ACIP) Under Part D

- Requires Part D sponsors to eliminate the deductible and coinsurance or other cost-sharing with respect to the ACIP-recommended vaccines
- IRA requires a temporary subsidy payment to the Medicare health and drug plans during 2023, for the reduction in cost sharing and deductible for ACIP recommended adult vaccines
- In 2023, the cost sharing amounts, including deductible, paid by the Part D plans count toward incurred costs for Medicare beneficiaries
- **Effective Date:** January 1, 2023

No Surprises Act Background and Purpose

- Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act) to add a new Part E.
- Generally, providers, facilities, and providers of air ambulance services must comply with these new requirements starting January 1, 2022.
- The provisions in Part E create requirements that apply to providers, facilities, and providers of air ambulance services, such as cost sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections.

No Surprises Act Background and Purpose (continued)

- These provider, facility, and provider of air ambulance services requirements generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, and Federal Employees Health Benefit plans. The good faith estimate requirement and the requirements related to the patient-provider dispute resolution process also apply to the uninsured.
- These requirements do not apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills.

Provider and facility requirements that apply starting January 1, 2022

- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
- Disclose patient protections against balance billing (PHSA 2799B-3; 45 CFR 149.430)

Provider and facility requirements that apply starting January 1, 2022 (continued)

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- Provide good faith estimate in advance of scheduled services, or upon request (PHSA 2799B-6; 45 CFR 149.610 (for uninsured or self-pay individuals))
- Ensure continuity of care when a provider’s network status changes (PHSA 2799B-8)
- Improve provider directories and reimburse enrollees for errors (PHSA 2799B-9)

CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency

Coronavirus Waivers & Flexibilities

https://www.cms.gov/coronavirus-waivers

CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency

https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf

Ending the COVID-19 Continuous Enrollment Condition

- Under the Consolidated Appropriations Act 2023 (CAA, 2023), enacted in December 2022, the FFCRA **Medicaid continuous enrollment condition ended on March 31, 2023.**
- States will resume normal operations**,** including **restarting** full Medicaid and CHIP eligibility renewals and **terminations of coverage for individuals who are no longer eligible.**
- States will be able to terminate Medicaid enrollment for individuals no longer eligible **beginning on April 1, 2023**.
- States will need to **address a significant volume of pending renewals** and other actions. This is likely to place a heavy burden on the state workforce and existing processes.
- When states resume full renewals, **over 15 million people could lose their current Medicaid or CHIP coverage.**[1] Many people will then be **eligible for coverage through the Marketplace or other health coverage** and need to transition.
- On January 30, 2023, the Biden-Harris Administration announced its intent to end the national emergency and PHE declarations related to the COVID-19 pandemic on **May 11, 2023.**

[1]Available at: https://aspe.hhs.gov/reports/unwinding-medicaid-continuous-enrollment-provision

Resuming Normal Eligibility and Enrollment Operations: Expectations of States

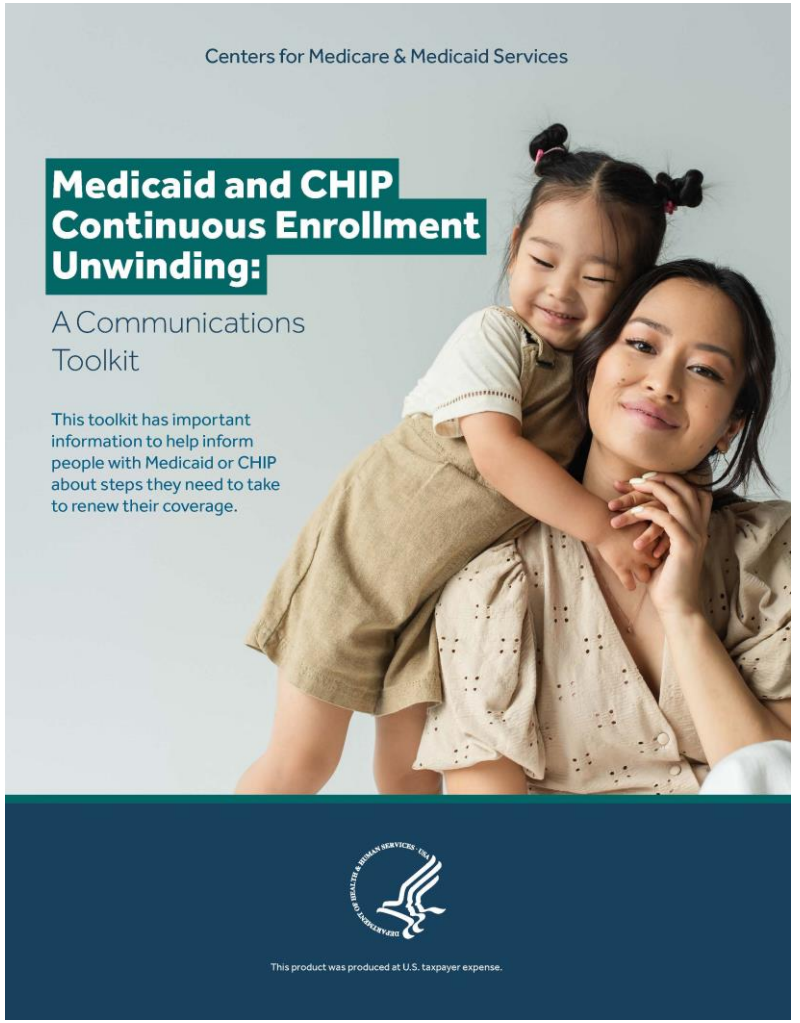
- When the continuous enrollment condition ends, states must **initiate** eligibility renewals for the state's entire Medicaid and CHIP population within **12 months** and **complete** renewals within **14 months**.
  - States may **begin this process in February, March, or April 2023** but may not terminate eligibility for most individuals in Medicaid prior to April 1, 2023
- States have **4 months** to resume timely processing of all applications, including those received after April 1, 2023.
- The Centers for Medicare & Medicaid Services (CMS) has **been working closely with states for over a year** to ensure that they are ready; that **eligible enrollees retain coverage** by renewing their Medicaid or CHIP; and that **enrollees eligible for other sources of coverage,** including through the Marketplace, smoothly transition.
- CMS has also issued an array of guidance and tools to support state processing of eligibility and enrollment actions, including new flexibilities and requirements for states.

Medicaid Unwinding Special Enrollment Period (SEP)

- To ensure individuals have sufficient time to enroll in Marketplace coverage during the unwinding period, consumers who lose Medicaid/CHIP coverage between **March 31, 2023** and **July 31, 2024** will be eligible for a **60-day SEP beginning the day they submit or update a Marketplace application.**
  - Consumers can access this Unwinding SEP by submitting or updating an application through HealthCare.gov, a certified partner that supports SEPs, or the Marketplace Call Center.
- CMS has published Marketplace guidance on the unwinding SEP: https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf
- CMS recommends that Medicaid/CHIP enrollees submit or update an application on HealthCare.gov as soon as they receive their Medicaid/CHIP termination letter from their state.
  - More information can be found at: https://www.healthcare.gov/medicaid-chip/transfer-to-marketplace/

Medicaid and CHIP Continuous Enrollment Unwinding: A Communications Toolkit

- A **living resource** where products will be added/updated as we learn more about what states, partners and consumers need to respond to
- Contains **important information** to help inform people with Medicaid or CHIP about **steps they need to take to renew their coverage**
- **Contents include**:
  - Overview
  - Summary of research with key insights
  - Key messages
  - Fillable digital flyers: “Have you heard the news? Your state Medicaid office is restarting eligibility reviews”
  - Drop in articles
  - Social media and outreach products
  - Emails
  - SMS/text messages
  - Call Center scripts
  - CMS Partner Tip Sheet
- **Available in English and Spanish.** Select resources available in Chinese, Hindi, Korean, Tagalog, and Vietnamese.



Call to Action and Key Messages for Partners

- **CMS Needs Your Help!**

- **What Partners Can Do NOW**
  - Right now, partners can help **prepare for the renewal process and educate Medicaid and CHIP enrollees about the upcoming changes**. This includes making sure that enrollees have updated their contact information with their State Medicaid or CHIP program and are aware that they need to act when they receive a letter from their state about completing a renewal form.

- **Key Messages for Partners to Share**
  - There are three main messages that partners should focus on now when communicating with people that are enrolled in Medicaid and CHIP.
    - **Update your contact information** – Make sure [Name of State Medicaid or CHIP program] has your current mailing address, phone number, email, or other contact information. This way, they'll be able to contact you about your Medicaid or CHIP coverage.
    - **Check your mail** – [Name of State Medicaid or CHIP program] will mail you a letter about your Medicaid or CHIP coverage. This letter will also let you know if you need to complete a renewal form to see if you still qualify for Medicaid or CHIP.
    - **Complete your renewal form (if you get one)** – Fill out the form and return it to [Name of State Medicaid or CHIP program] right away to help avoid a gap in your Medicaid or CHIP coverage.

- Sample social media posts, graphics, and drop-in articles that focus on these key messages can be found in the Communications Toolkit. The Unwinding resource page will continue to be updated as new resources and tools are released.

- Additional messaging will be shared in the future for Phase II, which focuses on ensuring Medicaid and CHIP enrollees take the necessary steps to renew coverage, or transition to other coverage if they're no longer eligible for Medicaid or CHIP once Unwinding begins.

Thank you!

Thank you for attending this session with CMS. We appreciate your time. We are always trying to improve our level of service to our customers and stakeholders. You can help us do that by providing your feedback on today's session. Please take a few moments to complete this brief evaluation. Just click on the link below to go to the evaluation. https://cmsgov.force.com/act/Evaluation

Title of the Event when asked: 5-CMS KAOM Annual Convention

Questions or want to partner?
Contact: ROkcmORA@cms.hhs.gov