



Current Topics

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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

CMS Strategic Plan

CMS Strategic Pillars

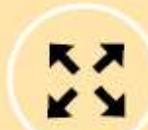
ADVANCE EQUITY

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' operations





Lesson 1

Original Medicare Updates

The Consolidated Appropriations Act, 2021 Medicare Provisions

- Beneficiary enrollment simplification
- Waive Medicare coinsurance for certain colorectal cancer screening tests
- Expanded access to mental health services furnished through telehealth
- Extended coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions

Beneficiary Enrollment Simplification

- Beginning January 1, 2023, Medicare coverage will become effective sooner for individuals enrolling in the last 3 months of their Initial Enrollment Period (IEP) or in the General Enrollment Period (GEP)
- Coverage for these individuals will be effective the month after their month of enrollment
- There are also technical changes to the calculation for Medicare late enrollment penalties
- Special Enrollment Periods (SEPs) with no late enrollment penalties may be established for individuals who meet exceptional conditions specified by the U.S. Department of Health & Human Services (HHS) Secretary

Beneficiary Enrollment Simplification

New Special Enrollment Periods (SEP)

Special Enrollment Period	Occurs From	Ends	Coverage Starts
Individual, or individual authorized representative, legal guardian, or caregiver was impacted by a disaster or emergency	The day the Federal, state or local government declares the emergency or disaster, or the date in that declaration (whichever is earlier).	6 months after whichever of these happens later: <ul style="list-style-type: none">✓ The end date in the original declaration✓ The last day of any extensions to the declaration✓ The date the government revokes or announces the end of the declaration	The month after enrollment is submitted

Beneficiary Enrollment Simplification

New Special Enrollment Periods (continued)

Special Enrollment Period	Occurs From	Ends	Coverage Starts
Health Plan or Employer Error	The day the individual notifies Social Security that the health plan or employer misrepresented or provided incorrect information	6 months after individual notifies Social Security	The month after enrollment
Formerly Incarcerated Individuals	The day the individual is released from incarceration	The last day of the 12th month after the month the individual is released	The month after enrollment or, the individual can choose retroactive back to their release date (not to exceed 6 months)
Termination of Medicaid Coverage	The day the individual is notified that Medicaid coverage is ending	6 months after Medicaid coverage ends	The month after enrollment unless the individual elects a start date of the first day of the month they lost Medicaid and agrees to pay all prior premiums
Other exceptional conditions	Once Social Security decides whether the individual qualifies for a SEP	Minimum 6-month duration	The month after enrollment

Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests

- Requires the amount of patient cost-sharing for colorectal cancer screening tests that remove a polyp or other tissue to gradually decrease
- Medicare to pay 100% of the cost in 2030
 - 80% for 2022
 - 85% for 2023–2026
 - 90% for 2027–2029

Expanding Access to Mental Health Services Furnished through Telehealth

Removes the geographic originating site restrictions and adds the home of the patient as a permissible originating site

- Services for the purpose of diagnosis, evaluation, or treatment of a mental health disorder
- Effective for services furnished on or after the first day after the end of the COVID-19 public health emergency (PHE)

Coverage of Immunosuppressive Drugs for Kidney Transplant Patients Extended

Extends immunosuppressive drug coverage for Medicare kidney transplant recipients beyond the 36-month limit

- Provides coverage under Medicare Part B (Medical Insurance) solely for immunosuppressive drugs. Individuals won't get Medicare coverage for any other items or services.
- Available to individuals for whom Medicare coverage ends, or will end, 36 months after the month in which an individual received a successful kidney transplant.
- Individuals may not be enrolled in certain other types of coverage.
- Coverage begins no earlier than January 1, 2023.

Extension of Coverage of Immunosuppressive Drugs for Kidney Transplant Patients (continued)

The new immunosuppressive drug benefit has the following features:

- There aren't specific enrollment periods; if an individual is eligible, they can enroll (or disenroll) at any time on a monthly basis
- The benefit only covers immunosuppressive drugs and doesn't include coverage for any other Part B benefits or services
- An individual is required to attest that they aren't enrolled in, and don't expect to enroll in, certain other types of coverage
- The premium is less than the standard Part B premium, and enrollees aren't subject to late enrollment penalties
- Individuals eligible for Medicare Savings Programs (MSPs) can get coverage for Medicare immunosuppressive drug benefit premium and cost sharing

Lowering Prices Through Drug Price Negotiation: Part B

- 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

Medicare Part B Drug Rebates & Coinsurance

The Inflation Reduction Act (IRA) created changes to Medicare Part B-covered drug pricing and coinsurance

- January 1, 2023 is the start of the first quarter for which drug manufacturers will be required to pay rebates to Medicare if prices for certain Part B drugs increase faster than the rate of inflation
- Starting April 1, 2023 people with Original Medicare may pay a lower coinsurance for some Part B drugs if the drug's price increased faster than the rate of inflation in a benchmark quarter
- The Part B inflation rebates for quarters in 2023 and 2024 must be invoiced by September 30, 2025

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.

Postal Service Reform Act of 2022

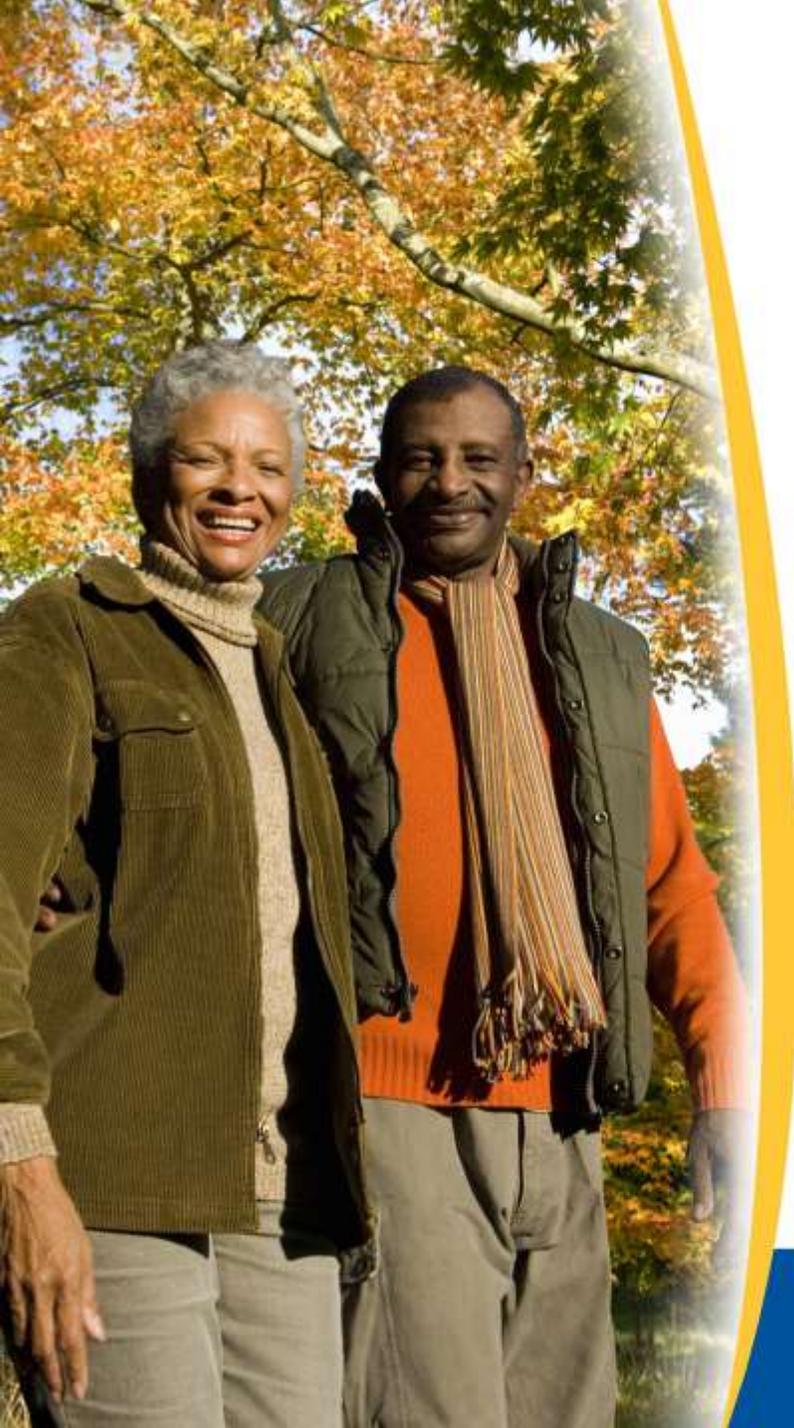
Medicare Enrollment Requirement

- Creates a new Postal Service Health Benefits (PSHB) program within the Federal Employees Health Benefits (FEHB) program
- Requires Medicare Part B enrollment for certain annuitants and their family members as a condition to keep their employer health benefits plan (starting January 1, 2025)
- Exception:
 - Current annuitants and current employees 64 and over, as of January 1, 2025
 - Annuitants and family members residing abroad
 - Annuitants and family members enrolled in Veterans Affairs (VA) or the Indian Health Service (IHS)

Medicare.gov Website Improvements

Redesigned landing page

- Previous experience:
 - Beneficiaries didn't know if they were where they need to be and what to expect
 - Beneficiaries didn't know the benefits of logging in and whether it was required to search for plans
- New experience:
 - Provides beneficiaries the option to login or create a [Medicare.gov](#) account, or easily jump-in and start searching for a plan
 - Clearly sets expectations for what's available in the tool and the benefits of creating an account first
 - More visually consistent with the new [Medicare.gov](#) branding



Lesson 2

Medicare Advantage Updates

Marketing & Communications Oversight

- Strengthens oversight of third-party marketing organizations to detect and prevent the use of confusing or potentially misleading activities to enroll beneficiaries in Medicare Advantage Plans and Medicare drug plans
- Reinstates the inclusion of a multi-language insert in all required documents to inform beneficiaries of the availability of interpreter services
- Requires a disclaimer for limited access to preferred cost sharing pharmacies
- Plan website instructions on how to appoint a representative, and website posting of enrollment instructions and forms

Beneficiary Access to Care During Disasters & Emergencies

- Revising and clarifying timeframes and standards associated with coverage obligations of Medicare Advantage Plans during disasters and emergencies that are declared under certain federal or by the governor of a state or protectorate
- Medicare Advantage Plan must comply with the special requirements when there's declaration of disaster or emergency (including public health emergency (PHE)) and disruption in access to health care in the Medicare Advantage Plan's service area

Network Adequacy

- Requires Medicare Advantage Plan applicants to demonstrate a sufficient network of contracted providers to care for beneficiaries before approval by CMS for a new or expanded Medicare Advantage contract
- Allow applicants to use Letters of Intent in lieu of a signed provider contract, at the time of application
- When coverage year starts (January 1) signed provider and facility contracts must be in place for the network

Lowering Prices Through Drug Price Negotiation: 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

Medicare Part D Drug Inflation Rebates

Requires manufacturers of a Part D rebatable drug to pay a rebate to Medicare

- If the drug's annual manufacturer price in an applicable period (a 12-month period beginning October 1, 2022) exceeds the drug's inflation adjusted payment amount
- Started October 1, 2022

Part D Improvements and Maximum Out-of-Pocket Cap for People with Medicare

Redesigns the Part D benefit and revises its parameters as follows:

- Eliminates cost-sharing in the catastrophic phase beginning in 2024
- Provides for Part D premium stabilization beginning in 2024, by capping base beneficiary premium increases per year to 6%
- Beginning in 2025:
 - Caps annual out-of-pocket costs for prescription drugs under Part D at \$2,000
 - Eliminates the coverage gap phase and coverage gap discount program, and replaces it with a manufacturer discount program that requires manufacturers to provide discounts on their “applicable drugs”
 - Creates a new Selected Drug Subsidy Program under which the government provides a subsidy (equal to 10% of the drug’s negotiated price) to Part D sponsors with respect to “selected drugs” dispensed to the sponsor’s enrollees who are in their initial phase of the Part D benefit
 - Provides all Part D beneficiaries an option to elect to pay cost sharing including coinsurance and the deductible up to the annual out-of-pocket (OOP) threshold for Part D-covered drugs in monthly amounts to allow the beneficiaries to spread their OOP costs over several months during the plan year

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

- 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

Expanding Eligibility for Extra Help (Low-Income Subsidy (LIS)) Under Part D

- Expands eligibility for the full LIS to individuals with income up to 150% of the federal poverty level (FPL)
- This change will provide the full LIS subsidy for those who currently qualify for the partial subsidy
- **Effective Date:** January 1, 2024

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



Lesson 4

Medicaid & the Children's Health Insurance Program (CHIP) Updates

Impact of the COVID-19 Public Health Emergency (PHE) on State Medicaid & CHIP Program Eligibility

- Implementation of federal policies and options to address the COVID-19 PHE have disrupted routine Medicaid and CHIP eligibility and enrollment operations and program enrollment has grown
- In March 2020, federal COVID-19 legislation established the “continuous enrollment condition,” allowing states to keep Medicaid beneficiaries enrolled through the end of the month in which the PHE ends as a condition for receiving a temporary increase in Medicaid federal funds
- While the continuous enrollment condition does not apply to separate CHIP, many states implemented temporary policy changes that had a similar impact on CHIP enrollment
- The continuous enrollment condition and temporary state changes to Medicaid and CHIP policies has prevented beneficiaries from losing health coverage during the PHE, and some states may have a large volume of Medicaid and CHIP enrollment work to complete

End Date Established for Increased FMAP and Continuous Enrollment Condition

- The Consolidated Appropriations Act of 2023 modified the Families First Coronavirus Response Act so that the FMAP increase and end of continuous enrollment are no longer tied to the end of the PHE
- Ends the continuous enrollment condition on March 31, 2023 (other current law conditions sunset with the FMAP increase on December 31, 2023)
- Phases out the 6.2 percentage point FMAP increase, beginning April 1, 2023 and ending December 31, 2023

Resuming Eligibility and Enrollment Operations (Unwinding)

- Per the requirements of the CAA, states will process Medicaid and CHIP renewals
- For some beneficiaries, this will be the first time their coverage will be renewed since the PHE began
- CMS is working with states and other stakeholders to ensure eligible beneficiaries maintain coverage and individual who become eligible for other forms of coverage transition between coverage programs during the unwinding
- CMS views the work of assisting Medicaid and CHIP beneficiaries' continuous enrollment unwinding as 2 phases:
 - Phase 1: Inform beneficiaries about renewing their coverage and encourage them to update their contact information now
 - Phase 2: Help Medicaid and CHIP beneficiaries take the necessary steps to renew coverage, and transition to other coverage if they're no longer eligible for Medicaid or CHIP.

What Partners Can Do NOW To Help Prepare for the Renewal Process

Phase 1

Partners can inform Medicaid and CHIP beneficiaries what they can do to prepare for renewing their coverage and available health coverage options

- There are three main messages that partners should focus on now when communicating with people that are enrolled in Medicaid and CHIP
 1. **Update your contact information** – Make sure the state has your current mailing address, phone number, email, or other contact information
 2. **Check your mail** – State will mail you a letter about your Medicaid or CHIP coverage
 3. **Complete your renewal form (if you get one)** – Fill out the form and return it to the State Medicaid or CHIP program right away to help avoid a gap in your Medicaid or CHIP coverage
- If they no longer qualify for Medicaid or CHIP, they may be able to buy a health plan through the Health Insurance Marketplace, and get help paying for it

What Partners Can Do NOW To Help Prepare for the Renewal Process (continued)

Phase 2

Ensure Medicaid and CHIP beneficiaries take the necessary steps to renew coverage, and transition to other coverage if they're no longer eligible for Medicaid or CHIP

Special Enrollment Periods

- Marketplace: if you lost Medicaid or CHIP coverage in the past 60 days or expect to lose coverage in the next 60 days
 - Medicare: lasts for 6 months after Medicaid termination and allows individuals to choose between retroactive coverage back to the date of termination from Medicaid (but no earlier than January 1, 2023) or coverage beginning the month after the month of enrollment
- Keep current on your state's timelines
 - Check back on [Medicaid.gov/Unwinding](https://www.Medicaid.gov/Unwinding) for updated messaging and resources

Improving Access to Adult Vaccines Under Medicaid & CHIP

- State Medicaid and CHIP programs will be required to provide coverage for approved adult vaccines recommended by the Advisory Committee on Immunization Practices (and their administration) without cost-sharing.
- The enrollees that must get such coverage are:
 - Most Medicaid Categorically Needy enrollees;
 - All Medicaid Medically Needy enrollees; and
 - CHIP enrollees 19 years of age or older (i.e., pregnant and postpartum individuals covered by CHIP)
- **Effective Date:** October 1, 2023 (the first day of the first fiscal quarter that begins on or after the date that is one year after enactment)



Appendices

Helpful Websites

- Electronic Code of Federal Regulations (eCFR) – [ecfr.gov](https://www.ecfr.gov)
- CMS Program Data – [data.CMS.gov](https://data.cms.gov)
- CMS Research – [CMS.gov/Research-Statistics-Data-and-Systems/Research-Statistics-Data-and-Systems](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research-Statistics-Data-and-Systems)
- CMS updates – [CMS.gov/newsroom](https://www.cms.gov/newsroom)
- CMS National Training Program – [CMSnationaltrainingprogram.cms.gov](https://www.cmsnationaltrainingprogram.cms.gov)

Acronyms

APTC Advance Premium Tax Credit

ADAP AIDS Drug Assistance Program

ARP American Rescue Plan Act of 2021

CAA Consolidated Appropriations Act, 2021

CHIP Children's Health Insurance Program

CMS The Centers for Medicare & Medicaid Services

CY Calendar Year

eCFR Electronic Code of Federal Regulations

EOB Explanation of Benefits

EOM Enhancing Oncology Model

ESRD End-Stage Renal Disease

FEHB Federal Employees Health Benefits

FFM Federally-facilitated Marketplace

FPL Federal Poverty Level

GEP General Enrollment Period

GHP Group Health Plan

HHS U.S. Department of Health & Human Services

HRA Health Reimbursement Arrangement

HRSN Health-Related Social Needs

IEP Initial Enrollment Period

IHS Indian Health Service

IRMAA Income-Related Monthly Adjustment Amount

IRS Internal Revenue Service

Feedback

Thank you for attending today's session. 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. Thank you very much.

CMSNYRO2StatewideWinter

<https://cmsgov.force.com/act/Evaluation>

Feedback

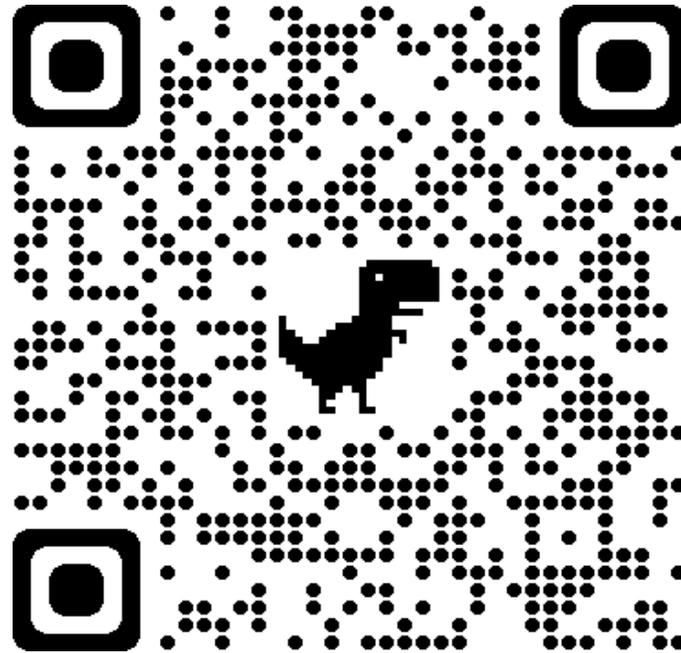


Image of a code that can be scanned to lead to the survey

Acronyms (continued)

LOI Letter of Intent

MAGI Modified Adjusted Gross Income

MSP Medicare Savings Program

OPM Office of Personnel Management

OT Occupational Therapy

PACE Programs of All-Inclusive Care for the Elderly

PHE Public Health Emergency

PSHB Postal Service Health Benefits

PT Physical Therapy

QHP Qualified Health Plan

QIO Quality Improvement Organization

QMB Qualified Medicare Beneficiary

RTBT Beneficiary Real Time Benefit Tool

SEP Special Enrollment Period

SHO State Health Official

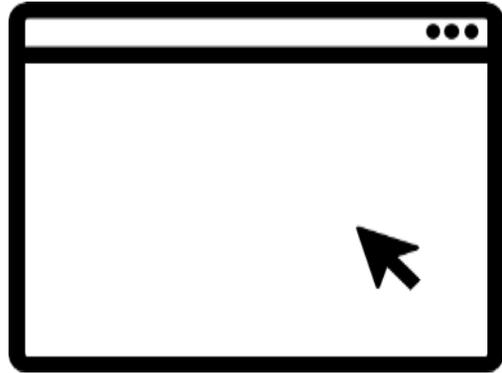
SLP Speech-Language Pathology

SPAP State Pharmaceutical Assistance Program

TrOOP True Out-of-Pocket

VA Veterans' Affairs

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CMSnationaltrainingprogram.cms.gov.



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