CMS Updates

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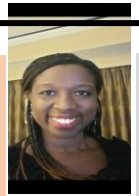

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CMS Key Initiatives

- Price Transparency
- Medicaid Renewals
- Inflation Reduction Act
- Medicare Open Enrollment
- Marketplace Open Enrollment
- Returning to Regular Operations after Covid-19
- Health Equity
- Opioids
- Flu/Immunizations
- E-health
- Open Payments
- Quality Payment Program
- Burden Reduction

Today's Topics

- Hospital Price Transparency
- No Surprises Act/Good Faith Estimates
- Medicaid Renewals
- Inflation Reduction Act

Hospital Price Transparency: Review of Compliance Requirements

Presenter: Catherine Snow

Hospital Price Transparency Final Rule Introduction

- On November 15, 2019, CMS finalized policies that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services

- Final rule:
  - Further advances the agency's commitment to increasing price transparency
  - Requirements apply to each hospital operating in the United States
  - Effective date is January 1, 2021

- The final rule implements Section 2718(e) of the Public Health Service Act and requires each hospital operating within the United States to establish (and update) and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act

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Hospital Price Transparency Final Rule Overview

- Starting on January 1, 2021, each hospital operating in the United States is required to make this information available in two ways:

As a comprehensive machine-readable file with all items and services

AND

As a display of shoppable services in a consumer-friendly format

- Prior guidance required hospitals to post their “chargemasters” online in a machine-readable format. The Hospital Price Transparency final rule requirements supersede the prior guidance.

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Standard Charges Must be Posted Two Ways

1) Comprehensive Machine-Readable File:

- A single machine-readable digital file containing the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.
- Based on public comment, we believe this information and format is most directly useful for employers, providers, and tool developers who could use these data in consumer-friendly price transparency tools or who may integrate the data into electronic medical records and shared decision-making tools at the point of care.

2) Consumer-Friendly Shoppable Services:

- Display of at least 300 “shoppable services” (or as many as the hospital provides if less than 300) that a health care consumer can schedule in advance. Must contain plain language descriptions of the services, group them with ancillary services, and provide the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.
- A ‘shoppable service’ is a service that can be scheduled by a health care consumer in advance.
- CMS deems a hospital in compliance if the hospital maintains an internet-based price estimator tool that meets the requirements provided in 45 CFR §180.60(a)(2).

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MRF Sample Formats and Tools

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Voluntary MRF Sample Templates

CMS recently released Version 1.1 of the voluntary MRF sample formats which are accompanied by a comprehensive data dictionary.

The CMS release included voluntary machine-readable sample formats and the accompanying resources (for example, data dictionary and validator tool) that hospitals can use to make public their standard charge information in an MRF.

- Sample format layouts are available in 1) CSV “wide” format, 2) CSV “tall” format, and 3) JSON schema. Interested parties indicated these formats and layouts are the most frequently used by hospitals.
- The data dictionary provides detailed information on how to use the sample formats to encode hospital standard charges and other information needed for context.
- The validator tool allows hospitals to check to make sure the MRF meets technical specifications before posting the file online.

Voluntary sample formats and tools can be found on the Hospital Price Transparency Resources Page.

Hospital Price Transparency Tools

How this tool helps

This validation tool helps identify basic issues in Hospital Price Transparency machine readable files: it checks whether the file matches the voluntary sample format published by CMS and will identify basic issues and errors for invalid data.

A file that passes these basic validation checks **does not mean that a file is guaranteed to be fully in compliance**.

This tool runs in the web browser, and uploading files here does not share these files with CMS. This validator tool is intended to be used with machine readable files that use the voluntary sample format published by CMS and will not work for files that do not use this formatting.

https://cmsgov.github.io/hpt-validator-tool/

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CY 2024 OPPS/ASC Proposed Rule

In the CY2024 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) proposed rule, CMS is proposing to require hospitals to encode data for a revised and expanded set of data elements in a CMS template layout.

In order to standardize MRF data, CMS is proposing to require that hospitals:

- Conform to a CMS template layout (offered as a CSV “wide” format, a CSV “tall” format, and a JSON schema).
- Encode all standard charge information, as applicable, that correspond to a set of required data elements, including: general data elements, each type of standard charge, description, and codes.
- Comply with specified technical instructions (such as a data dictionary).

If finalized, these requirements would become effective January 1, 2024. CMS is proposing an enforcement grace period until March 1, 2024. The proposed rule can be found on the CY2024 OPPS/ASC Proposed Rule Federal Register Page.

– **The 60-day comment period closed on September 11, 2023.**

Data Element Comparison Chart: Sample Format vs Proposed Rule

This table summarizes and compares the existing sample format data elements with the proposed required data elements.

Data Element	Sample Format	Proposed Rule
File Date	YES	YES
File Version	YES	YES
Hospital Name	YES	YES
Hospital License	YES	YES
Hospital Location	YES	YES
Hospital Address	*NO*	YES
Hospital Financial Aid Policy	YES	*NO*
Gross Charges	YES	YES
Cash Discounted Price	YES	YES
Payer-Specific Negotiated Charges*	YES	YES
Minimum and Maximum Deidentified Negotiated Charges	YES	YES
Consumer-Friendly Expected Allowed Amount	*NO*	YES
Item/Service Description	YES	YES
Billing/Accounting Codes, Modifiers, and Code Type	YES	YES
Billing Class	YES	*NO*
Setting (Inpatient or Outpatient)	YES	YES
Drug Unit and Type of Measurement	YES	YES

** By payer and plan; indicated as a dollar amount, percentage, or algorithm; type of contracting method*

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HPT Compliance Overview

Monitoring and Enforcement

CMS has the authority to monitor hospital compliance with Section 2718(e) of the Public Health Service Act, by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites:

- Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may issue a warning notice, request a corrective action plan, and impose a civil monetary penalty and publicize the penalty on a CMS website.
- Beginning January 1, 2021, if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, CMS may impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website.

Monitoring and Enforcement FAQs

Compliance Assessment

- During a comprehensive compliance review, CMS assesses whether the hospital's disclosure of standard charges meets the requirements specified at 45 CFR Part 180

- Specifically, CMS assesses whether the hospital has displayed standard charges in a machine-readable file in accordance with the criteria established at 45 CFR §180.50 and shoppable services in a consumer-friendly manner in accordance with the criteria established at 45 CFR §180.60

- Machine Readable Files and Shoppable Services/Price Estimator Tools are evaluated based on compliance with the regulatory requirements including, for example, the contents of the file, the file's accessibility, and date of last update.

Compliance Enforcement

After an initial review, if CMS determines a hospital's files are not in compliance with the final rule, the following actions typically occur.

1. CMS issues a **Warning Notice** indicating the violations*

1. If CMS determines that the hospital resolved the violations within 90 days after receiving the Warning Notice, CMS will issue a closure notice to the hospital. If, after 90 days, CMS determines the hospital has not resolved the violations, the hospital will receive a **Corrective Action Plan (CAP)** Request letter.

Though the compliance process typically begins with a **Warning Notice, hospitals that have not made a good faith attempt to satisfy the requirements (i.e., they have not posted any machine-readable file or shoppable services list/price estimator tool) will not receive a warning letter and will go straight to the **CAP phase**.*

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Compliance Enforcement (cont.)

- A Corrective Action Plan (CAP) is a document that outlines the hospital's violations, the processes/corrective actions the hospital will take to address each deficiency, and the timeframe by which the violations will be addressed.
- When a hospital receives a Request for Corrective Action Plan for being out of compliance with the hospital price transparency regulations, hospitals must submit a CAP within 45 days of the date of the request. The hospital must be in full compliance within 90 days from the date the Request for Corrective Action Plan was issued. In addition, the Request for Corrective Action Plan notice must be acknowledged by the hospital within **5 days** of receipt.
- The CAP must be signed and dated by the Chief Executive Officer/President. CAPs should be submitted to the HPT Compliance Mailbox (HPTCompliance@cms.hhs.gov). CMS has made available a voluntary sample CAP template for hospitals to use.
- Once the timeframe outlined in the CAP has passed, CMS will perform a review to determine if the violations have been addressed.

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Compliance Enforcement – Civil Monetary Penalties

If CMS determines that the violations are not resolved in accordance with the requirements of the CAP or a hospital is not responsive to CMS actions to address non-compliance *, the hospital may be subject to **Civil Monetary Penalties (CMPs)**

- The maximum daily CMP amount for hospitals with a bed count of 30 or fewer is $300/day. For hospitals with at least 31 and up to 550 beds, the maximum CMP is $10/bed/day. For hospitals with greater than 550 beds, the maximum daily CMP amount is $5,500. Under this approach, for a full calendar year of noncompliance, the minimum total penalty amount would be $109,500 per hospital, and the maximum total penalty amount would be $2,007,500 per hospital. Refer to CFR 180.90(c)(2).
- Once CMS issues a CMP, CMS will post the Notice of Imposition of the CMP on the CMS website.

A hospital has 30 calendar days from the issuance of the CMP to appeal the decision.

* *Effective 04-26-2023, CMS will now impose a CMP for nonresponsive hospitals that fail to submit a CAP and come into compliance at the end of the 45-day CAP submission deadline.*

Common Deficiencies Seen in 2023:

Of hospitals found to be noncompliant with the machine-readable file display, the most common deficiencies included:

- Failure to make public a single machine-readable file.
- Missing one or more of the five types of standard charges.
- Including all five types of standard charges but failing to clearly associate the payer-specific negotiated charges with the name of the third-party payer and plan.

Of hospitals found to be noncompliant with the consumer-friendly display, the most common deficiencies included:

- Failure to make available a consumer-friendly list of standard charges for shoppable services or to offer a price estimator tool
- Failure to include all corresponding data elements (such as the required types of standard charges, ancillary services, and relevant billing codes).

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CY 2024 OPPS/ASC HPT Compliance Proposed Changes

CMS is proposing several additions and modifications to its enforcement provisions at 45 CFR 180.70. These proposals are designed to improve CMS enforcement capabilities and improve the transparency of its enforcement activities. They include the following proposals:

- CMS may require submission of certification by an authorized hospital official as to the accuracy and completeness of the data in the machine-readable file and submission of additional documentation as may be necessary to determine hospital compliance.

- Require hospitals to submit an acknowledgement of receipt of the warning notice in the form and manner and by the deadline specified in the notice of violation issued by CMS to the hospital.

- In the event CMS takes an action to address hospital noncompliance and the hospital is determined by CMS to be part of a health system, CMS may notify health system leadership of the action and may work with health system leadership to address similar deficiencies for hospitals across the health system.

- CMS may publicize on the CMS website information related to 1) CMS's assessment of a hospital's compliance; 2) Any compliance action taken against a hospital, the status of such compliance action, and the outcome of such compliance action; and (3) Notifications sent to health system leadership.

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HPT Resources

Communication with CMS

HPT Compliance Mailbox

As a policy matter, CMS does not discuss a hospital's compliance status with anyone except the CEO/President of the hospital and/or the designated representative. To designate a representative the hospital should:

- Send an email to HPTCompliance@cms.hhs.gov notifying CMS of the appointment of someone other than the CEO/President of your hospital as the official representative of the organization for Hospital Price Transparency. The email must either originate from the CEO/President's corporate e-mail address or have an attached written designation signed by the CEO/President

- Include in the email the designee's name, title, e-mail, and phone number to ensure any confidential information will be shared only with your hospital's official representative

All compliance inquiries should be submitted to HPTCompliance@cms.hhs.gov

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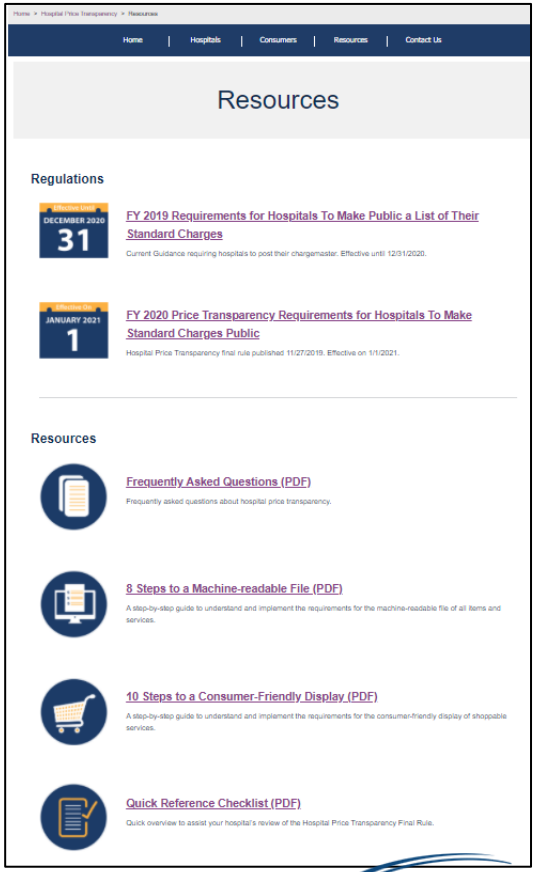
Hospital Price Transparency Webpage

Resources available at:

www.cms.gov/hospital-price-transparency

- Frequently Asked Questions
- 8 Steps to a Machine-Readable File
- 10 Steps to a Consumer-Friendly Display
- Quick Reference Checklist



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Contact Us

https://www.cms.gov/hospital-price-transparency/contact-us

Submit a Complaint

Can't find a hospital's standard charges online?

You may submit a complaint to CMS if it appears that a hospital has not posted information online.

Email a Question

Have a question about price transparency? Send an email to the hospital price transparency team.

PriceTransparencyHospitalCharges@cms.hhs.gov

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Questions & Answers Session

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Preventing Surprise Medical Bills

You have new rights

The No Surprises Act protects people from unexpected medical bills

- **Presenter: Angela Cain**

Who is Protected by the No Surprises Act?

- These surprise billing protections apply to consumers who get their coverage through their employer (including a federal, state, or local government employer), a multi-employer plan, or through the federal Marketplace or a state-based Marketplace, or who purchase coverage directly through a health insurance plan
- For those who are uninsured (or self-pay for care), this rule includes protections to ensure they know how much their health care will cost before they get it and have a way to challenge a bill if it is much larger than expected
- The rules don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Service, Veterans Affairs Health Care, or TRICARE, since each of these programs already has other protections against high medical bills

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Preventing Surprise Medical Bills

- The No Surprises Act and implementing regulations:
  - Ban surprise billing for emergency services
  - Ban high out-of-network cost sharing for emergency and non-emergency services
  - Ban out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances
  - Ban out-of-network charges for air ambulance services
  - Ban other out-of-network charges without advance notice

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Protecting Uninsured/Self-pay Patients: The Good Faith Estimate

- The No Surprises Act also protects uninsured (or self-pay) individuals from unexpected medical bills. Starting January 1, 2022, a provider or facility must give an uninsured (or self-pay) individual a good faith estimate of expected charges after an item or service is scheduled or upon request
- The good faith estimate will include expected charges for the primary item or service the individual is receiving, as well as for any other items or services that would reasonably be expected to be provided as part of the same scheduled or requested items/services

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Protecting Uninsured/Self-pay Patients: The Good Faith Estimate

- The good faith estimate must be provided:
  - For an item or service scheduled at least three business days in advance: within one business day of scheduling
  - For an item or service scheduled at least 10 business days in advance: within three business days of scheduling
  - For an item or service that is not yet scheduled: within three business days of the request

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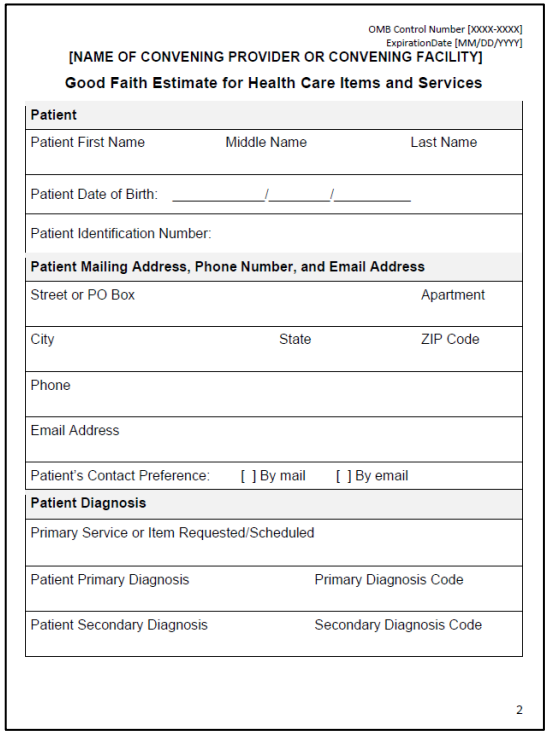
Example of a Good Faith Estimate



OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

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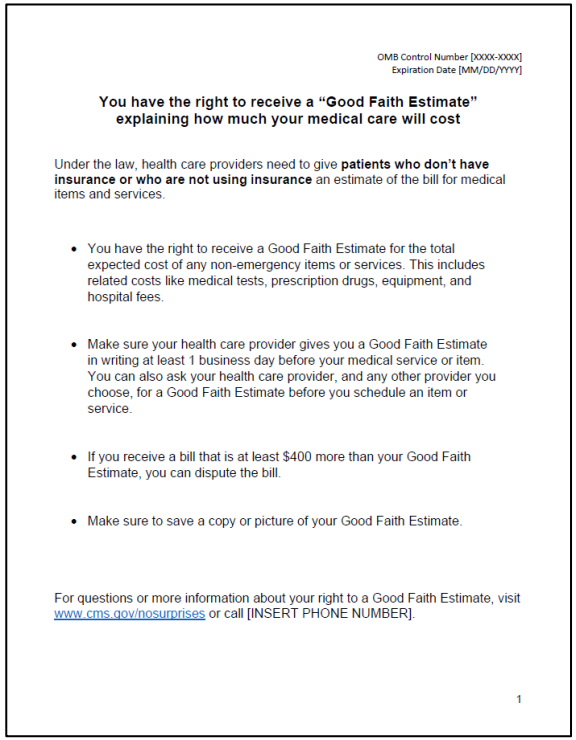

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Expiration Date [MM/DD/YYYY]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

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NSA Resources for Providers and Consumers

CMS No Surprises Website:
https://www.cms.gov/nosurprises

Medical Bill Rights Website:
https://www.cms.gov/medical-bill-rights

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Call the No Surprises Help Desk

- Get answers about your medical billing situation and see if the No Surprises Act applies. Or call to submit a complaint.
- We're available 7 days a week: weekdays from 8:00 am - 8:00 pm Eastern Time (ET), and weekends from 10:00 am – 6:00 pm ET.
- We can help you in Spanish, French, Arabic, Russian, Nepali, and over 350 other languages. Call us for resources in accessible formats like large print, Braille, and audio.
- Call our Help Desk at **1-800-985-3059**
- https://www.cms.gov/medical-bill-rights

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The End of the Continuous Enrollment Condition: What Partners Need to Know About Medicaid and CHIP Coverage

Historical Trends in Medicaid & CHIP Enrollment

As of February 2020 around **71 million** people were enrolled in Medicaid and CHIP

Approximately 17 million people lose Medicaid or CHIP coverage each year. Many find coverage through the Marketplace, Medicare, or their employer. Some also return to Medicaid or CHIP.

As of March 2023 more than **93 million** people were enrolled in Medicaid and CHIP.

https://www.medicaid.gov/resources-for-states/downloads/unwinding-cont-enroll-condition-infographic.pdf

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Ending the COVID-19 Continuous Enrollment Condition

- Under the Consolidated Appropriations Act, 2023 (CAA, 2023), enacted in December 2022, the Families First Coronavirus Response Act's **Medicaid continuous enrollment condition ended on March 31, 2023.**
- States have resumed normal operations**,** including **restarting** full Medicaid and CHIP eligibility renewals and **terminations of coverage for individuals who are no longer eligible.**
- States started terminating Medicaid enrollment for individuals no longer eligible **as of April 1, 2023**.
- States are **addressing a significant volume of pending renewals** and other actions. This is likely to place a heavy burden on the state workforce and existing processes.
- As 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.

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Resuming Normal Eligibility and Enrollment Operations: Expectations of States

- Now that the continuous enrollment condition has ended, states have started eligibility renewals for the state's entire Medicaid and CHIP population. States will be distributing renewals over a **12-month period** and will **complete** renewals within **14 months**.
  - Between now and the middle of 2024, everyone with Medicaid or CHIP coverage will need to renew their coverage.
  - Your state timeline can be found at https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reltd-ren-06292023.pdf
- 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.

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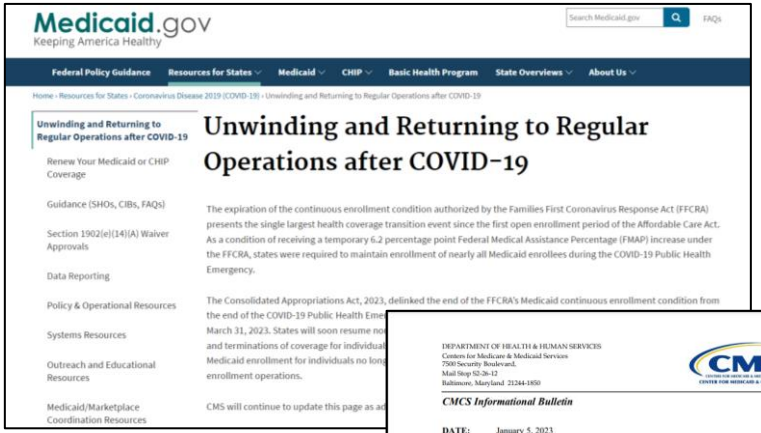
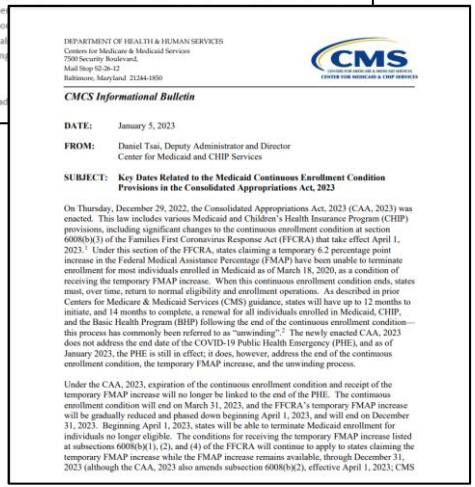
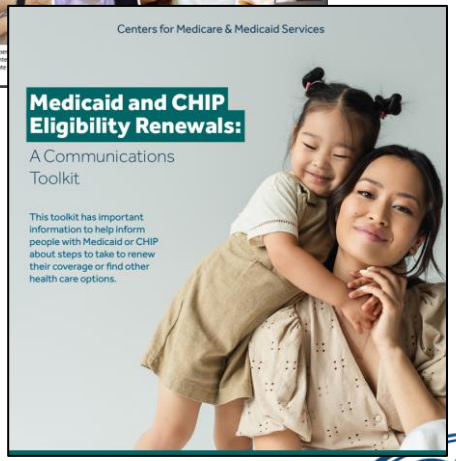
Medicaid.gov/Unwinding:
Resource Page for States and Partners







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Medicaid.gov/Renewals: Resources for Medicaid and CHIP Enrollees

Medicaid.gov
Keeping America Healthy

Search Medicaid.gov | FAQs

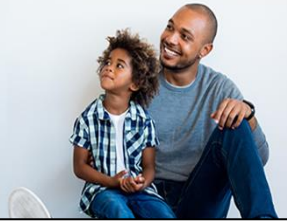
Federal Policy Guidance | Resources for States | Medicaid | CHIP | Basic Health Program | State Overviews | About Us

- Renew Your Coverage
- Apply for Coverage
- CMS Strategic Plan
- Agency Mission

Renew Your Coverage

Check your Medicaid notice or contact your state Medicaid office for more information.

Prepare Now



Get ready to renew now

Here are some things you can do to prepare for the renewal process:

1. **Update your contact information -** Make sure your state 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.
2. **Check your mail -** Your state will mail you a letter about your coverage. This letter will let you know if you need to complete a renewal form to see if you still qualify for Medicaid or CHIP.
3. **Complete your renewal form (if you get one) -** Fill out the form and return it to your state right away to help avoid a gap in your coverage.

If you no longer qualify for Medicaid or CHIP

You may be able to buy a health plan through the Health Insurance Marketplace®, and get help paying for it. Marketplace plans are:

- 4 out of 5 enrollees can find plans that cost less than $10 a month.
- Plans cover things like prescription drugs, doctor visits, urgent care, hospital visits, and more.

Explore Marketplace plans and savings

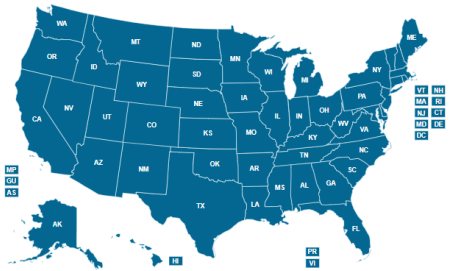
Medicaid or CHIP State Map

Select your state to get Medicaid enrollment information. You can also scroll down to find your state's contact information.

Select State

Select state

Select a State



★ STATE MEDICAID ENROLLMENT LINKS ★

Alabama

- Enrollment
- ☎ General Questions: 334-242-5000

Alaska

- Enrollment
- ☎ Alaska Recipient Helpline toll free 800-780-9972
  ☎ Eligibility helpline: 800-478-7778

American Samoa

- ☎ Medicaid Office: 684-699-4777
- ☎ Department of Public Health: 684-633-7676 / 684-633-4606

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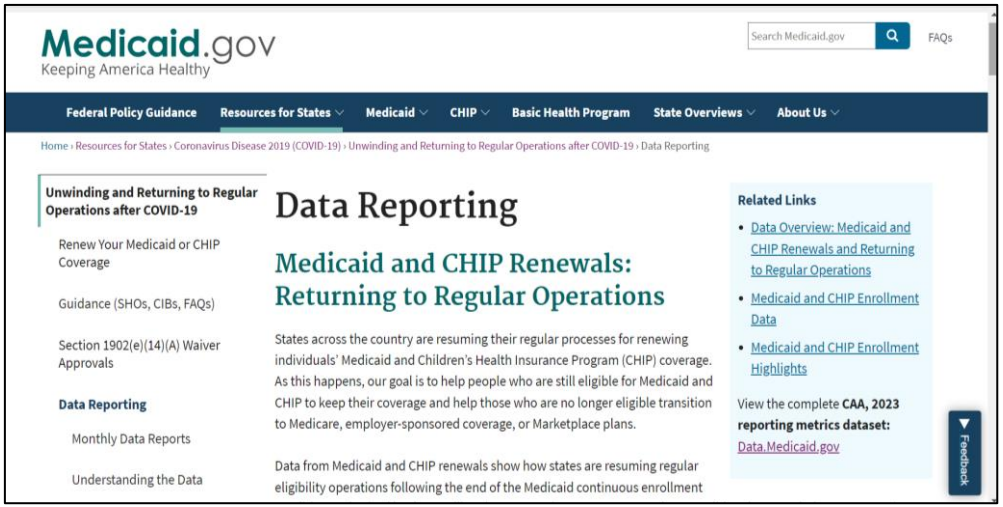
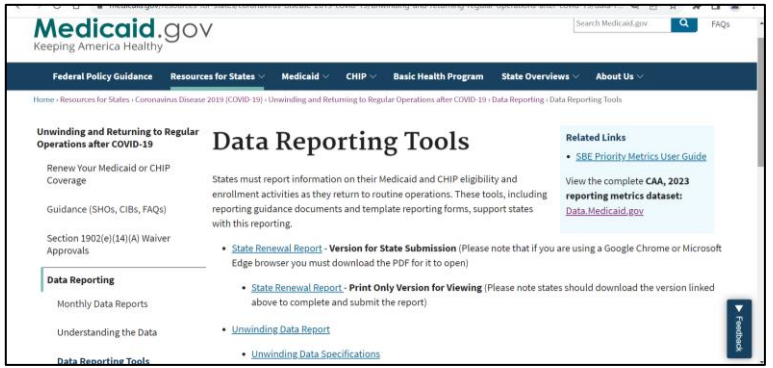
Medicaid.gov/Unwinding-Data: Data Reporting





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Medicaid and CHIP Continuous Eligibility Renewals: 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** or **transition to another health coverage option if no longer eligible for Medicaid or CHIP**
- **Contents include**:
  - Overview
  - Summary of research with key insights
  - Key messages
  - Fillable digital flyers
  - Drop in articles
  - Social media and outreach products
  - Emails
  - SMS/text messages
  - Call Center scripts
  - CMS Partner Tip Sheet
  - Factsheets
- **Available in English and Spanish.** Select resources available in Chinese, Hindi, Korean, Tagalog, and Vietnamese.

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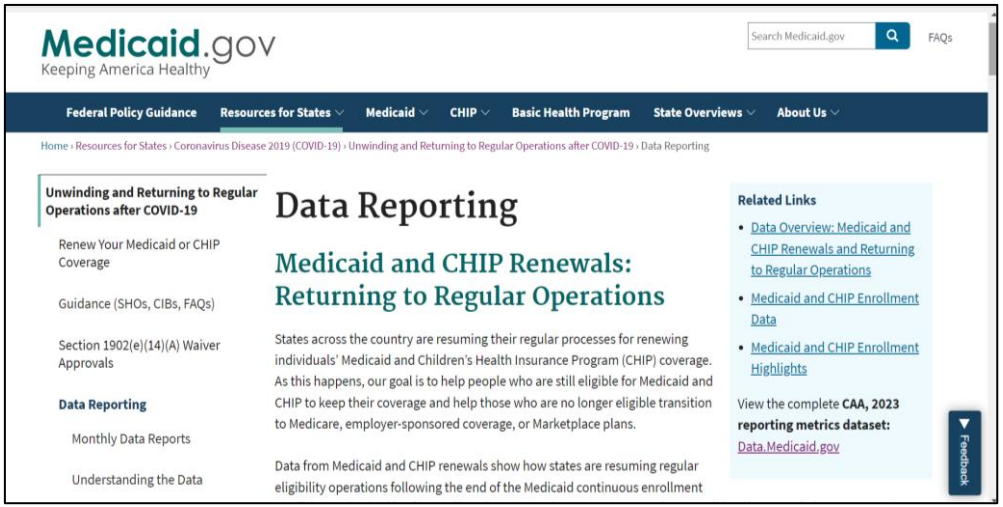
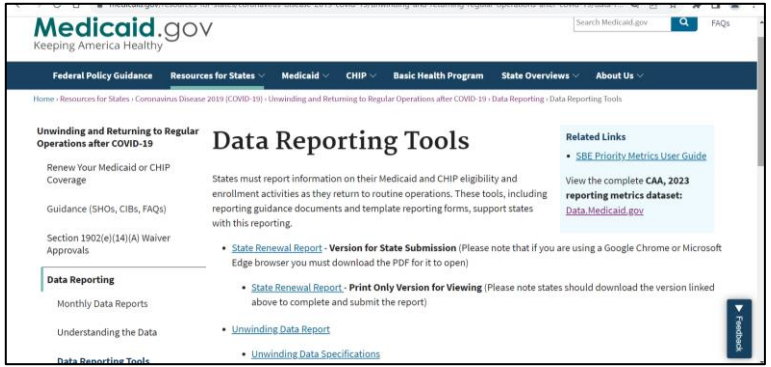
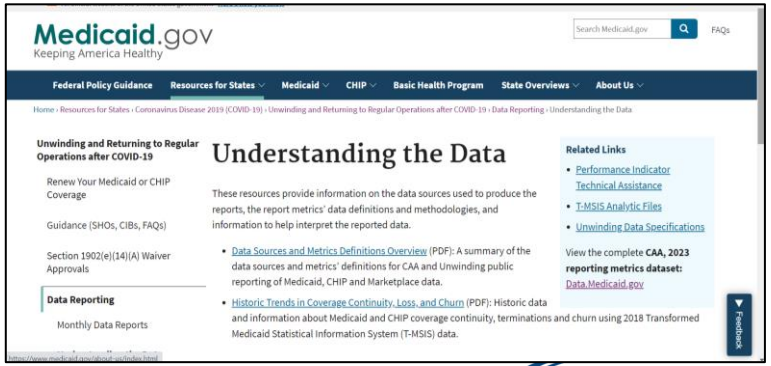
Medicaid.gov/Unwinding:
Helping People Who Have Lost Medicaid or CHIP Coverage







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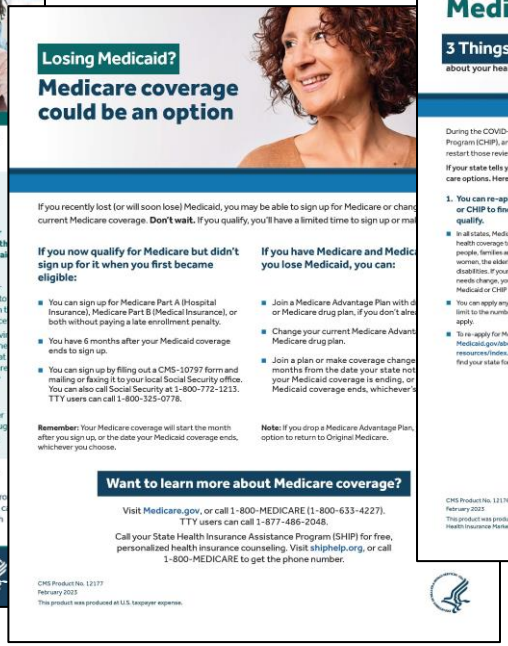
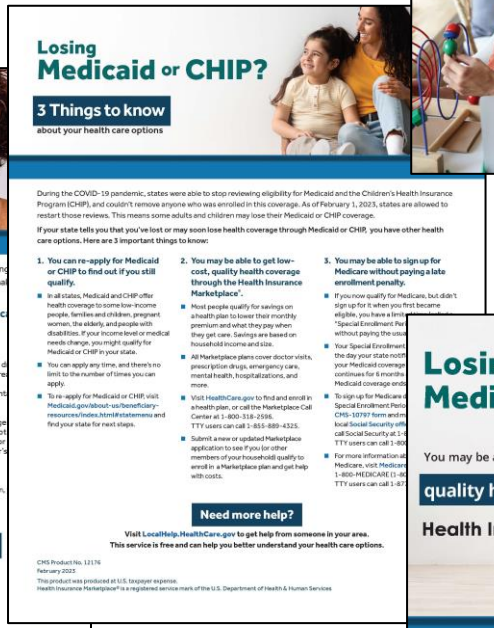
Medicaid.gov/Unwinding:
Helping People Who Have Lost Medicaid or CHIP Coverage





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Medicaid.gov/Unwinding: Fraud Resources

Model language for states – Scam alert

Say no to scams!

[State Medicaid or CHIP program name] is committed to protecting you and your family from scams. We're currently doing [Medicaid or CHIP] eligibility reviews, and we may be reaching out to you soon about your [Medicaid or CHIP] coverage. For more information about these eligibility reviews, visit [state Medicaid or CHIP website with unwinding information].

[State Medicaid or CHIP program name] will never threaten you or your family or ask for your credit card information or payment to keep or qualify for health coverage.

Scammers may pretend to be from a legitimate organization or government agency. They may contact you by phone, text, or email to try to steal money or something of value from you. **Don't share your personal information or give money** to anyone saying you have to pay them to keep [Medicaid or CHIP] coverage.

Report it if you get a call, email, or text that:

- Asks for your personal information (like your Social Security Number)
- Requests money (like credit card payment, gift cards, cash, prepaid debit card, or cryptocurrency
- Threatens you or anyone in your household with legal action

If this happens to you, call us at [insert state Medicaid or CHIP program phone number], report it to the Federal Trade Commission, and contact your local police department.

Avoid scams and get accurate [Medicaid or CHIP] renewal information at [Medicaid or CHIP website].

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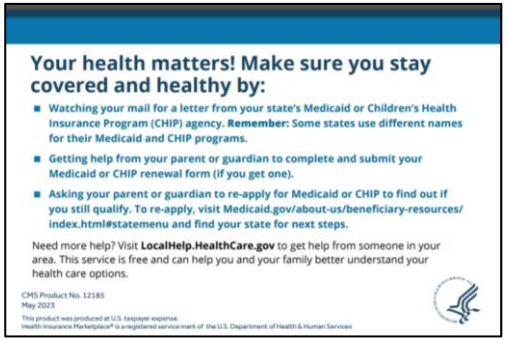
Medicaid.gov/Unwinding: Messaging and Resources for Kids and Families



Your health matters! Make sure you stay covered and healthy by:

- Watching your mail for a letter from your state's Medicaid or Children's Health Insurance Program (CHIP) agency. **Remember:** Some states use different names for their Medicaid and CHIP programs.
- Getting help from your parent or guardian to complete and submit your Medicaid or CHIP renewal form (if you get one).
- Asking your parent or guardian to re-apply for Medicaid or CHIP to find out if you still qualify. To re-apply, visit Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu and find your state for next steps.

Need more help? Visit **LocalHelp.HealthCare.gov** to get help from someone in your area. This service is free and can help you and your family better understand your health care options.

CMS Product No. 12185
May 2023
This product was produced at U.S. taxpayer expense.
Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services

- **Check your mail for a letter from your state.** If you get a Medicaid or CHIP renewal form, complete and submit it right away.
- **Apply for coverage even if you don't think you're eligible.** Your kids might qualify, even if you don't. To re-apply, visit **Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu** and find your state for next steps.
- **Explore low-cost, quality health coverage options** for young adults in your family through the Health Insurance Marketplace®.

Need more help? Visit **LocalHelp.HealthCare.gov** to get help from someone in your area. This service is free and can help you better understand your family's health care options.

CMS Product No. 12183
May 2023
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Medicaid.gov/Unwinding: Faith-Based Toolkit

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Medicaid.gov/Unwinding: Outreach to Special Populations

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Free CMS Printed Product Ordering

Several materials on the Outreach and Education Resources page are available for free to order through the CMS Product Ordering website. Some of these materials include:

- Postcard for Kids with Medicaid or CHIP (English and Spanish)
- Postcard for Renewing Kids' Medicaid or CHIP (English and Spanish)
- Fillable Flyer (English and Spanish)
- Non-fillable Flyer (English, Spanish, Chinese, Hindi, Korean, Tagalog, Vietnamese)
- HealthCare.gov Postcard (English and Spanish)
- Health Care Options Fact Sheet (English and Spanish)
- Tear Off Pad (English and Spanish)

To order free printed materials, visit https://productordering.cms.hhs.gov/pow/. If you do not have an account, you will need to request an account on the login page. Once you log into your account, you can enter the term "Unwinding" in the search bar to view the materials that are available for order.

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Call to Action and Key Messages for Partners

- **CMS Needs Your Help!**

- **What Partners Can Do NOW**
  - Right now, partners can help **support the renewal process and educate Medicaid and CHIP enrollees about** the recent **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 four main messages that partners should focus on now when communicating with people that are enrolled in Medicaid and CHIP.

    - **UPDATE** your contact information with your state Medicaid or CHIP Agency.
    - **RESPOND** to the Medicaid/CHIP renewal form when it arrives to keep your coverage.
    - **PARENTS** should respond even if you don't think you're eligible – your kids could still be eligible.
    - **CONSIDER OTHER COVERAGE OPTIONS:** If you are no longer eligible for Medicaid or CHIP, check if you can get coverage through your employer, through the Affordable Care Act Marketplace at HealthCare.gov, or through Medicare.

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

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Health Insurance Marketplace

Federally-Facilitated Marketplace (FFM): Updates on Plans for Medicaid Unwinding

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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 **continuous 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.
  - Consumers who lose Medicaid or CHIP coverage during this timeframe can submit or update a Marketplace application anytime and will have 60 days after that to pick a plan. Consumers will receive the Unwinding SEP automatically based on their answers to application questions.
- 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/

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How to Get Help Applying for Marketplace Coverage

If individuals need help completing a Marketplace application, they can:

- Visit HealthCare.gov
  - HealthCare.gov will direct individuals to their state-based Marketplace, as applicable
- Call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325)
- Visit https://localhelp.healthcare.gov/ to make an appointment with someone in their area who can help

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The Inflation Reduction Act and Medicare: Part D Improvements and Changes to Medicare Part B

Under the Inflation Reduction Act, out-of-pocket costs for insulin in Medicare are now capped at $35 per month's supply for a covered insulin product under Part D, as of January 1, 2023, with a similar cap taking effect in Part B on July 1, 2023

Part D Benefit Improvements:

- Insulin available at $35/month's supply of each covered insulin product
- ACIP-recommended adult Part D vaccines covered without cost-sharing
- A yearly cap ($2,000 in 2025) on out-of-pocket prescription drug costs in Medicare
- Expansion of the low-income subsidy program (LIS or "Extra Help") under Medicare Part D to individuals with limited resources and incomes below 150% of the federal poverty level starting in 2024

Changes to Medicare Part B:

- Improves access to high quality, affordable biosimilars for people with Medicare
- Imposes a $35/month cost-sharing cap on insulin pumps used as durable medical equipment

Presentation Feedback

Thank you for participating in this session with CMS Local Engagement & Administration – Dallas Office. We appreciate your time you have spent with us. We are always trying to improve our level of service to our partners 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, voluntary post-engagement evaluation. Just click on the link or use the QR code below. Your answers will help us improve our collaboration with you.

Activity Name: " 6 – CMS Dallas - Louisiana Rural Health Summit – CMS Updates"

***Note:* Please do not forward or post the link anywhere; this is an internal evaluation to assist us with this specific activity. Thank you!**

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

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Q&A

Thank you!