CMS Updates

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Local Engagement & Administration

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Health Equity
  - Social Determinants of Health
  - CMS Accomplishments
  - Chronic Care Management (CCM)
  - Coverage to Care (C2C)
- Inflation Reduction Act
- Hospital Price Transparency

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

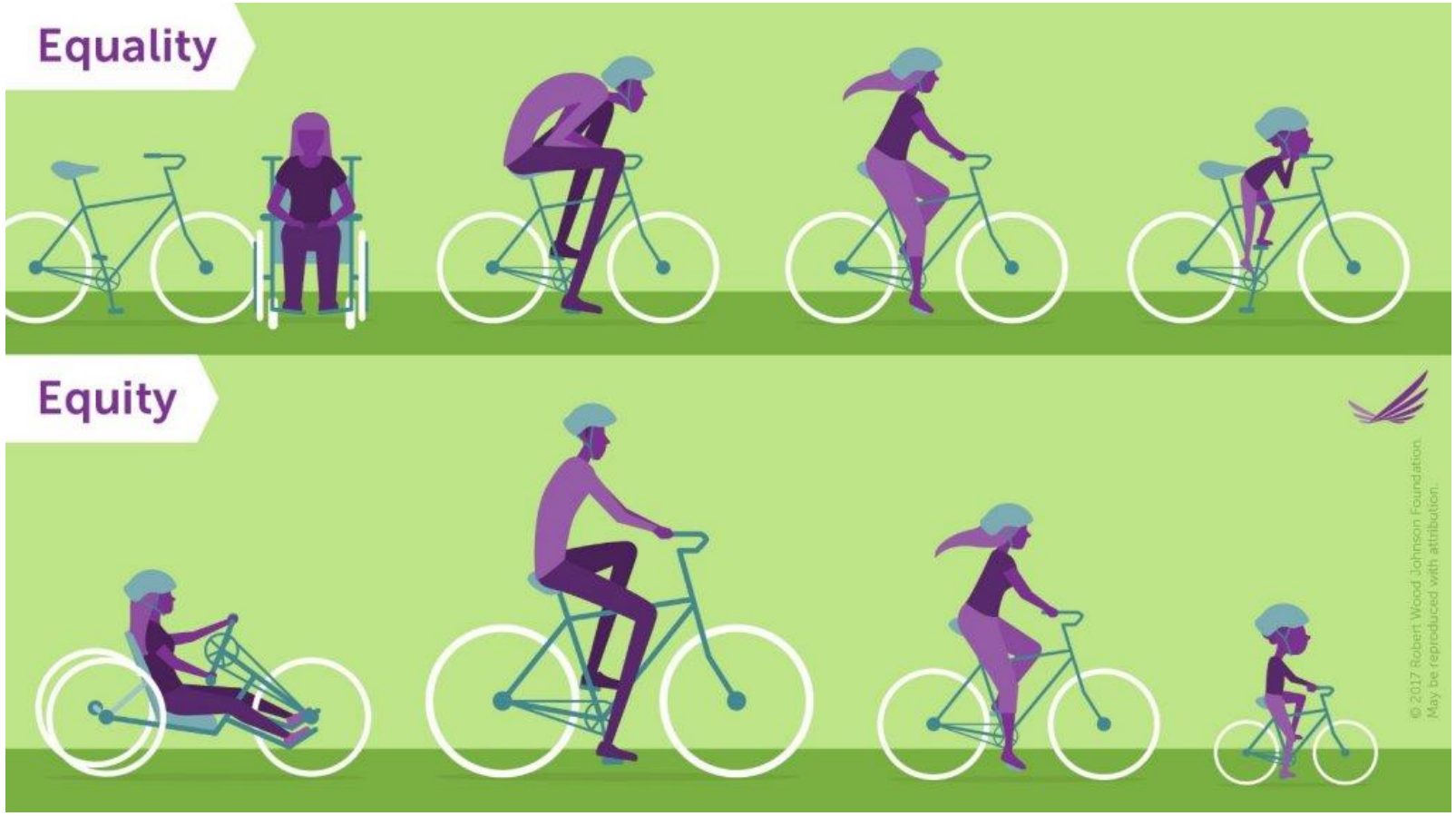
Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

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

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.



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CMS Framework for Health Equity

- Operationalize health equity across all CMS programs: Medicare, Marketplace, Medicaid, and CHIP
- Is evidence-based and informed by decades of research and stakeholder input
- Review the framework: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity

CMS Framework for Health Equity 2022–2032

Definition of Health Equity

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, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

CMS Framework for Health Equity Priorities

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 and Coverage

To read the CMS Framework for Health Equity 2022-2032, visit go.cms.gov/framework.

The CMS Office of Minority Health offers health equity technical assistance resources, aimed to help health care organizations take action against health disparities. If you are looking for assistance, visit go.cms.gov/omh or email HealthEquityTA@cms.hhs.gov.

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CMS Framework for Health Equity: 5 Priority Areas

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

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Social Determinants of Health (SDOH)

What are Social Determinants of Health?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[1]

Why are SDOH important?

It's estimated that between 70-90% of health is determined by SDOH. This doesn't mean that the clinical encounter doesn't matter – but instead, that health and health outcomes are influenced by the context of a person's place and space in society.

1 Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved July 15, 2022, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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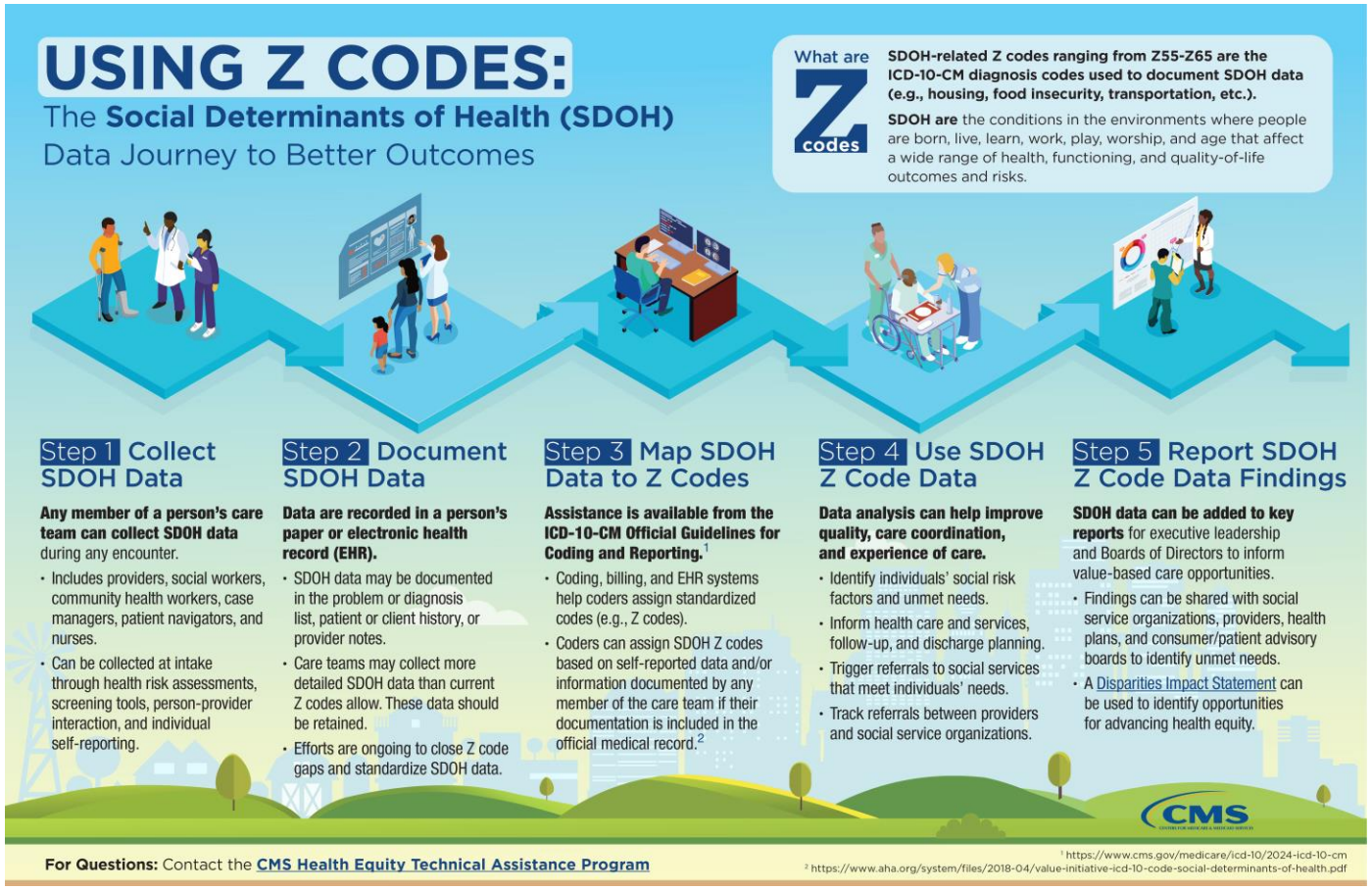
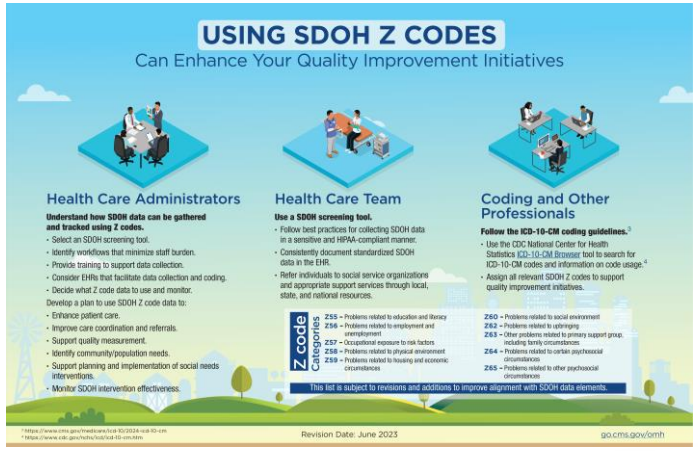
Z Codes Journey Map Infographic



A step-by-step infographic for health care administrators, health care team members, and coding professionals to understand the best practice and importance of gathering and tracking SDOH data.



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CMS Accomplishments for 2023: Health Equity

- Through the Maternity Care Action Plan, CMS is seizing every opportunity to improve maternity care access and quality, improve health outcomes, and reduce disparities.
- CMS established the first-ever Birthing-Friendly designation, a consumer-friendly indicator that a hospital or health system is committed to improving maternal health. This designation is displayed on the Care Compare section of the CMS website.
- CMS announced the Transforming Maternal Health (TMaH) Model that aims to reduce disparities in maternal health care access and treatment, improve outcomes and experiences for mothers and their newborns, and reduce overall Medicaid program expenditures.
- CMS released the CMS Sickle Cell Disease (SCD) Action Plan, which highlights CMS actions in four key areas: expanding coverage and access; improving quality and the continuum of care; advancing equity and engagement; and examining data and analytics.
- The Contract Year 2024 Medicare Advantage and Part D Final Rule strengthened behavioral health network adequacy in Medicare Advantage and advanced health equity through changes to the Star Ratings program, which will reward Medicare Advantage and Part D plans that provide excellent coverage for underserved populations.

CMS Accomplishments for 2023: Health Equity (cont.)

- The Oral Health Cross-Cutting Initiative (Oral Health CCI) was launched in 2023. Under the Oral Health CCI, CMS considers opportunities to expand access to oral health coverage using existing authorities and health plan flexibilities for Medicare, Medicaid, CHIP, and the Marketplaces. Access to oral health services is critical to achieve the best health possible.

- CMS awarded a new cohort of grants to minority-serving institutions through the Minority Research Grant Program (MRGP). The grant will support researchers across the country using CMS data to understand and help eliminate barriers to access, quality, and outcomes among underserved and Tribal communities.

- CMS expanded coverage in the Medicare Annual Wellness Visit (AWV) to include an optional Social Determinants of Health (SDOH) Risk Assessment, administered by way of a standardized, evidence based SDOH risk assessment tool.

- CMS implemented the first ever voluntary hospital reporting Social Determinants of Health (SDOH) measures, such as the Facility Commitment to Equity measure and the SDOH screening measure in a number of CMS quality reporting and value-based purchasing programs.

- In 2023, CMS introduced “Rewarding Excellent Care for Underserved Populations” in the Hospital Value-Based Purchasing Program and Skilled Nursing Facility Value-Based Purchasing Program, which rewards these providers if they provide high quality care and serve a high proportion of underserved patients.

Recent CMS Announcements

- Announced April 4, 2024 - Contract Year (CY) 2025 Medicare Advantage and Part D Final Rule
  - Requires that Medicare Advantage plans include an expert in health equity on their utilization management committees and for the committees to conduct an annual health equity analysis of the plans' prior authorization policies and procedures.

- Announced April 10, 2024 - Fiscal Year (FY) 2025 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule
  - CMS is proposing to take an additional step and better account for the resources involved in furnishing care to individuals experiencing housing insecurity. CMS is also proposing to add new social determinants of health data elements into LTCH quality reporting, requiring LTCHs to report elements on housing, food and utility stability, and access to transportation, which are factors that influence the resources required for their care.

  - As part of CMS' ongoing efforts to drive improvements in access to quality care during pregnancy, childbirth, and postpartum, CMS sought public comment (through June 10, 2024) on potential solutions that can be implemented through the hospital Conditions of Participation (CoPs).

Chronic Care Management (CCM)

- CCM is care coordination outside of a regular office visit for patients with 2+ chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.
- It provides access to care outside of and in between doctors' visits.
- CCM services can also help reduce geographic and racial or ethnic health care disparities.

Coverage to Care

What is C2C?

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

Updated translations available for all C2C consumer materials in at least 8 languages.

- **Personal Health Literacy:** the degree to which individuals are able to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Organizational Health Literacy:** the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

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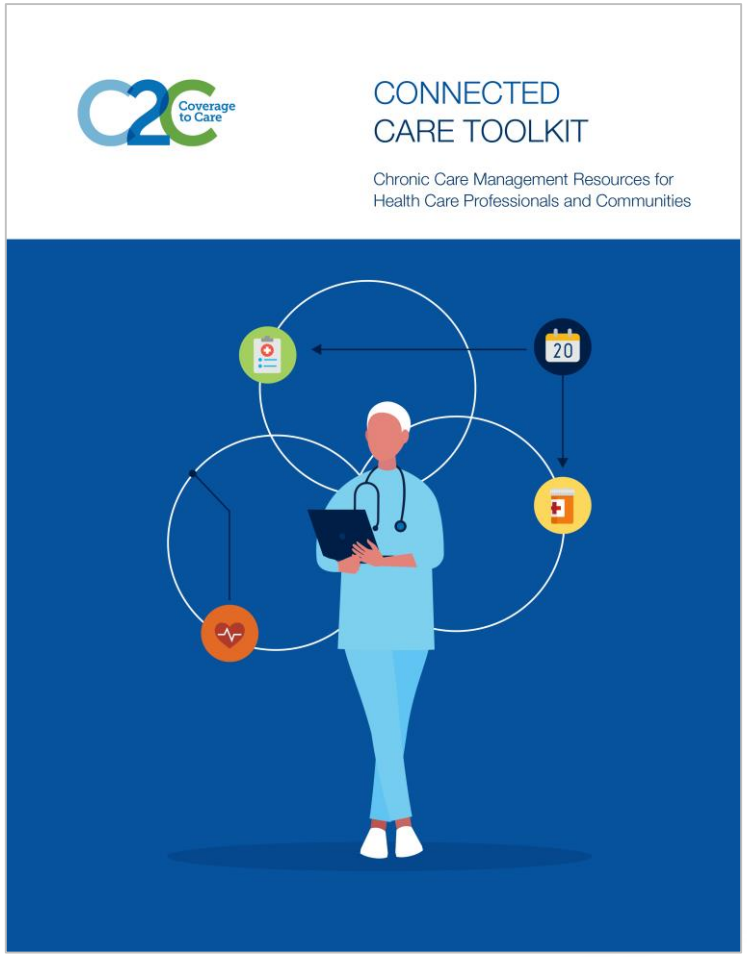
Roadmap to Better Care

- Explains what health coverage is and how to use it to receive primary care and preventive services
- Includes consumer tools:
  - Eight Steps to Better Care
  - Insurance card
  - Primary care vs. Emergency care
  - Explanation of Benefits
- Available in nine languages, Tribal version, and a customizable version
- Roadmap to Better Care PDF

Provider Resources

- The CMS Care Management page includes CCM resources, including fact sheets, FAQs, and data on chronic conditions in Medicare.
- Resource categories include:
  - Advance Care Planning
    - Advance Care Planning Services Fact Sheet
    - Advance Care Planning Services FAQs
  - Behavioral Health Integration
    - Behavioral Health Integration Services Booklet
    - Behavioral Health Integration FAQs
  - Chronic Care Management
    - Chronic Care Management Services Fact Sheet
    - Chronic Care Management Frequently Asked Questions
    - Chronic Care Management and Connected Care
    - Chronic Conditions in Medicare
    - Chronic Conditions Data Warehouse
  - Transitional Care Management
    - Transitional Care Management Services Fact Sheet
    - Billing FAQs for Transitional Care Management 2016



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Chronic Care Management (CCM) Resources

WHAT IS CHRONIC CARE MANAGEMENT?

If you have Medicare or are dually eligible (Medicare and Medicaid) and live with two or more chronic conditions that worsen your quality of life and put your health at risk, chronic care management (CCM) services can help connect the dots so you can spend more time doing what you love. Examples of these chronic conditions include—but are not limited to—arthritis, cancer, depression, diabetes, and high blood pressure. Services may include:

- **At least 20 minutes a month** of care coordination from a health care professional outside of in-person office visits, such as phone check-ins and access to a secure electronic patient portal
- **Personalized assistance** from a dedicated health care professional who will work with you to create your care plan
- **Coordination of care** between your pharmacy, specialists, testing centers, hospitals, and more
- **24/7 emergency access** to a qualified health care professional and expert assistance with setting and meeting your health goals

go.CMS.gov/ccm

CCM Factsheet

CHRONIC CARE MANAGEMENT PROVIDER(S) CHECKLIST

- ☐ **Identify patient eligibility for CCM services.**
  - Eligible CCM patients will **have multiple (2 or more) chronic conditions expected to last at least 12 months** or until the patient's death.
  - Identify patients who require CCM services by **using criteria suggested in CPT guidance** (like number of illnesses, number of medications, repeat admissions, or emergency department visits) or the **typical patient profile in the CPT prefatory language**.
- ☐ **Initiate a face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE) as an initiating visit** for new patients or patients who the billing practitioner hasn't seen within 1 year before CCM services start.
  - Assess the patient's medical, functional, and psychosocial needs.
  - Make sure the patient receives timely recommended preventive services.
  - Oversee the patient's medication self-management.
- ☐ **Provide informed consent and inform patient(s) that:**
  - CCM services are available.
  - They may have cost sharing responsibilities.
  - Only one practitioner can furnish and bill CCM services during a calendar month.
  - They can stop the CCM services at any time (effective the end of calendar month).

go.CMS.gov/ccm

CCM Checklist

WHAT IS CHRONIC CARE MANAGEMENT (CCM)?

CCM is the care coordination that is outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. According to estimates from the Centers for Medicare & Medicaid Services, one in four adults, including 70% of Medicare beneficiaries, have two or more chronic health conditions, qualifying them for CCM.[1]

CCM services may be billed by:

- Physicians and certain Non-Physician Practitioners (Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospitals, including Critical Access Hospitals

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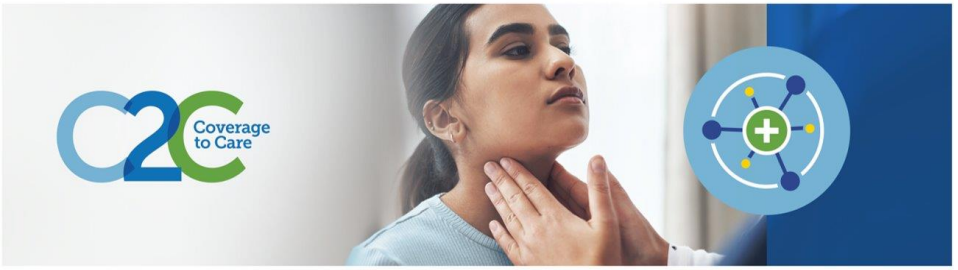
CCM At-A-Glance Checklist

C2C Prevention Resources

CMS OMH created resources in multiple languages, free of charge organization and consumers, to help health care professionals and national and community organizations support consumers as they navigate their coverage.



Consumer Resources | Prevention Resources | Order Printed Copies

Patient Resources:

- The Prevention Resources page focuses on prevention and healthy living. Materials can be shared with consumers, reposted online, printed, or ordered.

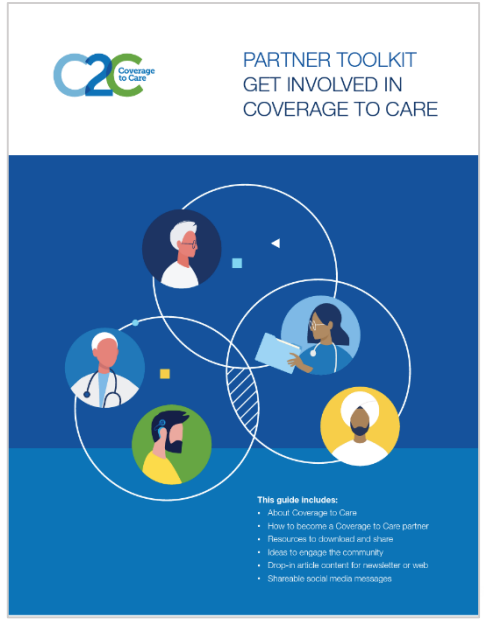
- Resources include:
  - Adults Preventive Services Flyer
  - Women Preventive Services Flyer
  - Men Preventive Services Flyer
  - Teens Preventive Services Flyer
  - Children Preventive Services Flyer
  - Infants Preventive Services Flyer
  - Put Your Health First Tabloid

Provider Resources

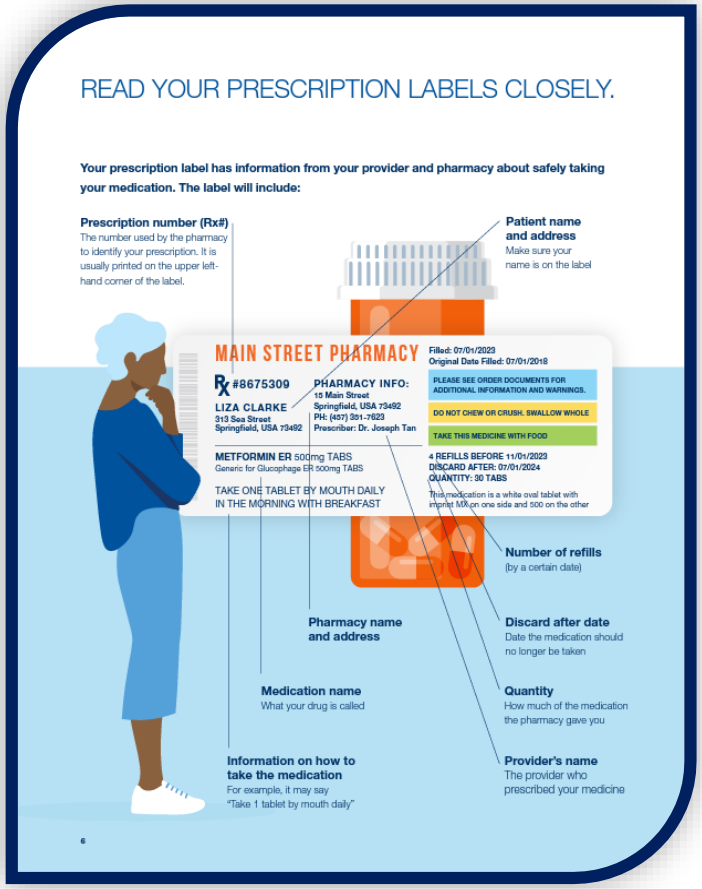
- Whether providers represent an organization or are an individual community advocate, they can be part of the important effort to improve the health of our nation. CMS encourages the sharing of C2C resources in churches, clinics, health systems, and your community settings.

Resources include:

- New C2C COVID-19 Materials
- Partnership Toolkit
- C2C Community Presentation
- Telehealth for Providers: What You Need to Know
- Manage Your Health Care Costs
- Enrollment Toolkit
- Stay Safe: Getting the Care You Need at Home
- Fillable Test Results Card
- Fillable Contact Information Card
- Fillable Appointment Reminder Card



Prescription Resource



Who in your community is using C2C resources?

- Congressional Offices
- Voter Rights Organizations
- Legal Aid Societies
- Colleges and Universities
- United Way
- State Health Insurance Assistance Program Counselors
- Primary Care Associations
- Dialysis Facilities
- Ryan White Providers
- Libraries
- Justice System
- Community Health Centers
- Hospitals
- Insurance Companies
- State and County Health Departments
- Area Agencies on Aging
- Tribal Organizations
- Assisters and Brokers
- Faith-Based Organizations

Using C2C Resources

1

- **Start the Conversation.** Use the *Roadmap to Better Care* as a tool to help people understand their new coverage and understand the importance of getting the right preventive services.

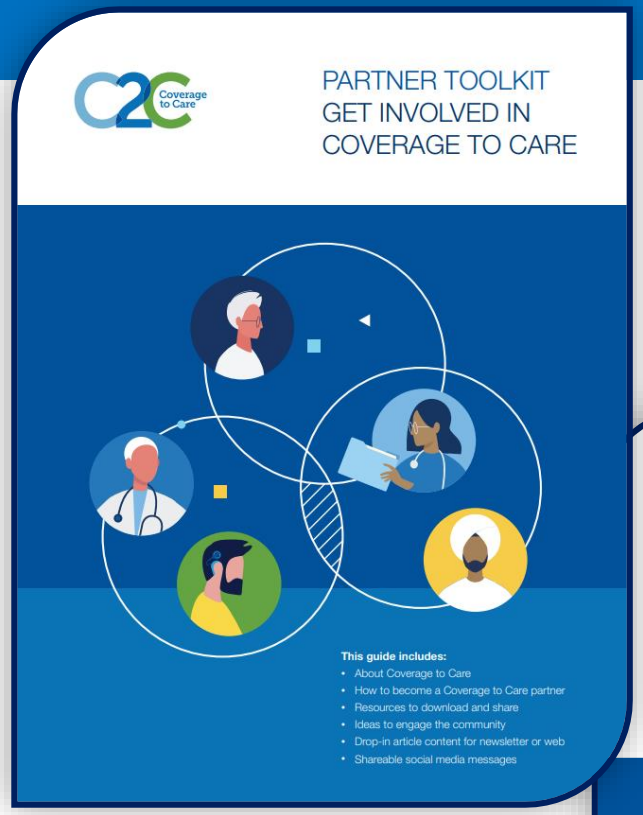
2

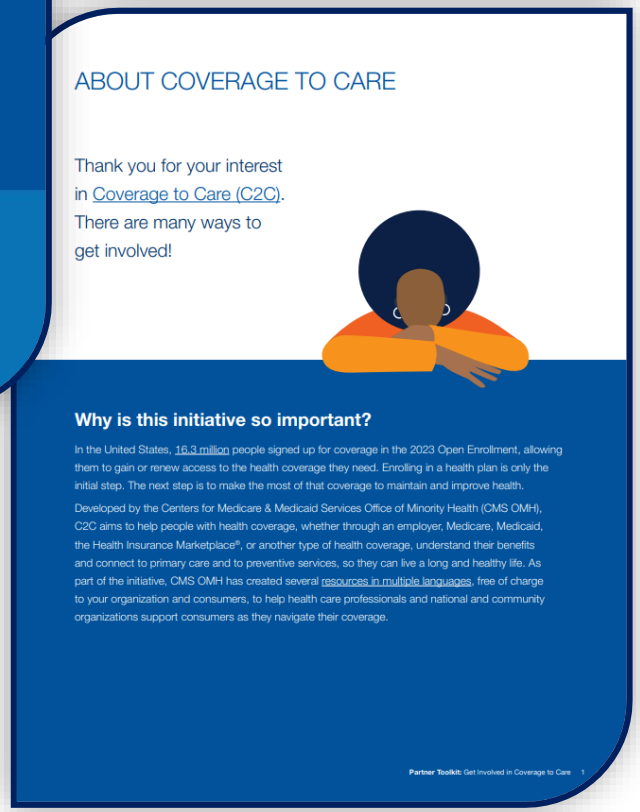
- **Help Consumers Understand.** The *Roadmap to Better Care* has a lot of information for consumers. You can help them use it as a resource to refer to as they journey to better health and well-being.

3

- **Personalize It.** You know your community. Consider adding local resources and information.

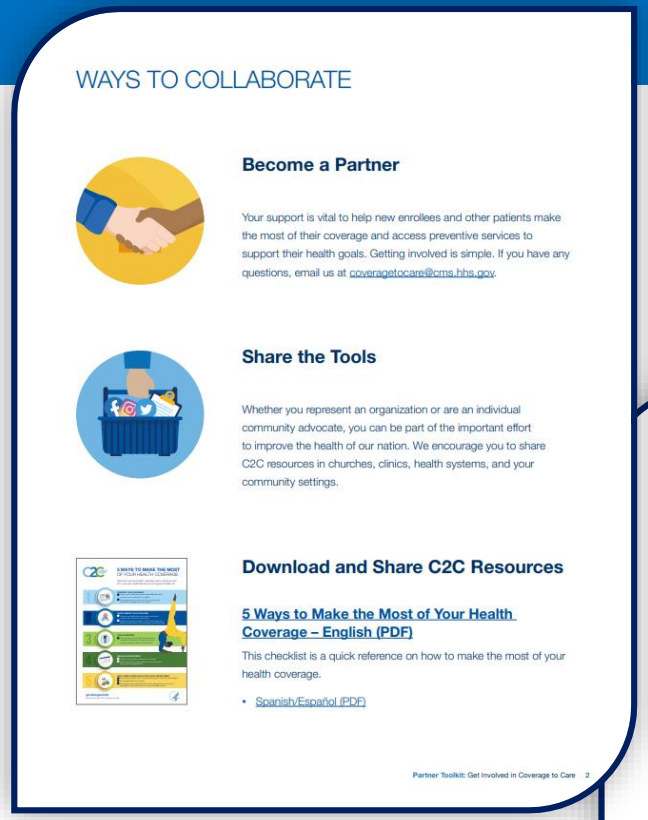
Partner Toolkit





- High-level document offering prospective and current partners information on how to share C2C materials
- Includes:
  - Significance of the C2C initiative
  - How to collaborate
  - Downloadable and printable resources
  - How to plan a C2C-based event
  - Guide on how to draft written content
- English and Spanish content
- Partner Toolkit PDF

Partner Toolkit (continued)



WAYS TO COLLABORATE

Become a Partner

Your support is vital to help new enrollees and other patients make the most of their coverage and access preventive services to support their health goals. Getting involved is simple. If you have any questions, email us at coveragetocare@cms.hhs.gov.

Share the Tools

Whether you represent an organization or are an individual community advocate, you can be part of the important effort to improve the health of our nation. We encourage you to share C2C resources in churches, clinics, health systems, and your community settings.

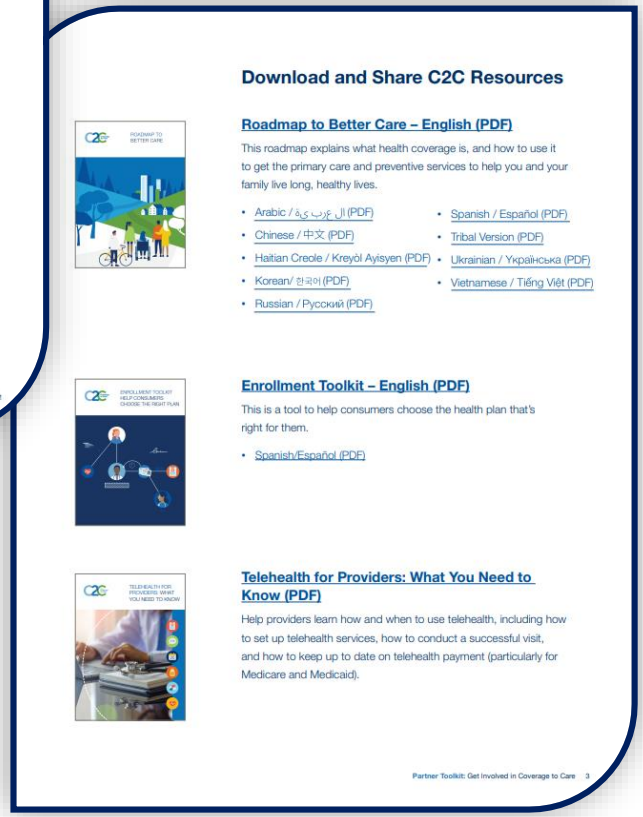
Download and Share C2C Resources

5 Ways to Make the Most of Your Health Coverage – English (PDF)

This checklist is a quick reference on how to make the most of your health coverage.

- Spanish/Español (PDF)

Partner Toolkit: Get Involved in Coverage to Care 2



Download and Share C2C Resources

Roadmap to Better Care – English (PDF)

This roadmap explains what health coverage is, and how to use it to get the primary care and preventive services to help you and your family live long, healthy lives.

- Arabic / عربي ال (PDF)
- Chinese / 中文 (PDF)
- Haitian Creole / Kreyòl Ayisyen (PDF)
- Korean/ 한국어 (PDF)
- Russian / Русский (PDF)
- Spanish / Español (PDF)
- Tribal Version (PDF)
- Ukrainian / Українська (PDF)
- Vietnamese / Tiếng Việt (PDF)

Enrollment Toolkit – English (PDF)

This is a tool to help consumers choose the health plan that's right for them.

- Spanish/Español (PDF)

Telehealth for Providers: What You Need to Know (PDF)

Help providers learn how and when to use telehealth, including how to set up telehealth services, how to conduct a successful visit, and how to keep up to date on telehealth payment (particularly for Medicare and Medicaid).

Partner Toolkit: Get Involved in Coverage to Care 3

Use the Partner Toolkit

- Ideas on how to get involved: C2C-based events to host in your community, sample text to use in a blog, newsletter, social media posts and graphics, and a web badge
- Available in English and Spanish

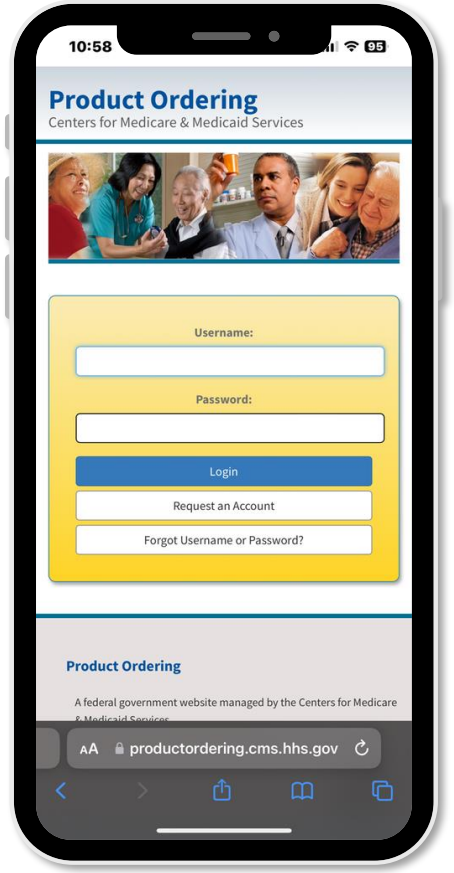
Use the C2C Community Presentation

- Overview of the *Roadmap to Better Care* with all eight steps, including slides, script, and a handout
- Available in English and Spanish

Order and share C2C resources at no cost to your organization.

Send stories to coveragetocare@cms.hhs.gov.

Order Coverage to Care Materials



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CoverageToCare@cms.hhs.gov

Rural Health
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Health Equity Technical Assistance Program
HealthEquityTA@cms.hhs.gov

Federal Grant Opportunities
Fed_CMPGrant@cms.hhs.gov.

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Inflation Reduction Act (IRA)

Overview of the Provisions of the New Prescription Drug Law

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Overview of the Inflation Reduction Act

- The Inflation Reduction Act (IRA) was signed into law in August 2022.
- The new law makes improvements to Medicare that will expand benefits, lower drug costs, and improve the sustainability of the Medicare program for generations to come.
- The law provides meaningful financial relief for millions of people with Medicare by improving access to affordable treatments and strengthening Medicare, both now and in the long run.

Inflation Reduction Act (IRA) CMS Provisions

- Places a $35 monthly out-of-pocket cap on Medicare-covered insulins
- Makes ACIP-recommended vaccines free under Medicare Part D prescription drug coverage
- Temporarily increases Medicare payment for qualifying biosimilars to encourage use
- Requires manufacturers to pay rebates to Medicare if their price increases for certain drugs exceed inflation
- Makes Medicare Part D prescription drug coverage more affordable

Inflation Reduction Act CMS Provisions (continued)

- This Year: People with very high prescription drug costs will no longer pay once they reach the “catastrophic phase”
- This Year: Full low-income subsidy expanded for people with low incomes, lowering premiums and out-of-pocket costs for their prescription drug coverage
- 2025: All people with Medicare Part D will have a $2,000 annual out-of-pocket cap on their drug costs
- Allows Medicare to negotiate the price of certain high-cost, brand name prescription drugs

The Medicare Drug Price Negotiation Program (1 of 3)

- Medicare will be able to negotiate (and re-negotiate) drug prices of certain high expenditure Medicare drugs with drug manufacturers

- For the drug companies of selected drugs that elect to participate in the Negotiation Program, the maximum fair prices that are negotiated will apply beginning in 2026

The Medicare Drug Price Negotiation Program (2 of 3)

- For the first year of the Negotiation Program, CMS selected 10 high expenditure, single source drugs for negotiation on August 29th, 2023

- On October 2nd, CMS announced that the drug companies who manufacture all 10 drugs selected for the Medicare Drug Price Negotiation Program for the first cycle have chosen to participate in the Negotiation Program.

- CMS will select up to an additional 15 drugs for negotiation for 2027, up to an additional 15 drugs (including drugs covered under Part B) for 2028, and up to an additional 20 drugs for 2029 and subsequent years

The Medicare Drug Price Negotiation Program (3 of 3)

The negotiated maximum fair prices for the first 10 drugs will apply beginning in 2026

October 1, 2023
Deadline for companies of drugs selected for the Negotiation Program to sign agreements to participate in the negotiation process for 2026.

October 2, 2023
Deadline for companies of drugs selected for the Negotiation Program to submit manufacturer-specific data to CMS to consider in the negotiation of maximum fair price.

February 1, 2024
CMS sends initial offers of a maximum fair price with a justification for a selected drug to each company participating in the Negotiation Program. The negotiation period begins.

March 2, 2024
Companies have 30 days from receiving offers of a maximum fair price for a drug to accept the offer or propose a counteroffer, if desired.

August 1, 2024
The negotiation period ends.

September 1, 2024
CMS will publish maximum fair prices for drugs selected for negotiation for 2026.

Part D Improvements

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

- People with very high prescription drug costs will no longer pay once they reach the “catastrophic phase”
- Provides for Part D premium stabilization beginning this year, by capping base beneficiary premium increases per year to no more than 6% through 2029
- Beginning in 2025:
  - People with Medicare prescription drug coverage will benefit from a yearly cap ($2,000 in 2025) on what they pay out-of-pocket for covered prescription drugs, starting in 2025. They’ll also have the option to pay their prescription costs in monthly amounts spread over the year rather than all at once, beginning in 2025.
  - The new discount program will require drug manufacturers to pay discounts on certain brand-name drugs and other types of drugs called biologics and biosimilars, both in the initial coverage phase and in the catastrophic phase of the Medicare prescription drug benefit. In general, manufacturers must provide a 10% discount in the initial phase and a 20% discount in the catastrophic phase.

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

- Requires Part D sponsors to eliminate the deductible and other cost sharing with respect to the ACIP-recommended adult vaccines
- Includes:
  - Shingles
  - RSV
  - Other recommended vaccines
- Effective Date: January 1, 2023

Improving Access to Adult Vaccines Under Medicaid & CHIP

- State Medicaid and CHIP programs are required to provide coverage for approved adult vaccines recommended by the ACIP (and their administration) without cost sharing

- **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)

Expansion of Extra Help

- Since January 1, 2024, nearly 300,000 low-income people with Medicare currently enrolled in the Extra Help program are newly eligible for expanded benefits including no deductible, no premiums and fixed, lowered copayments for certain medications. An additional 3 million people could benefit from the Extra Help program now but aren't currently enrolled

- Expands eligibility for the full low-income subsidy (LIS) benefit (also known as "Extra Help") to individuals with limited resources and incomes up to 150% of the federal poverty level

- People with Medicare who are currently enrolled in partial Extra Help have been automatically converted to full Extra Help; they don't need to take any action

Insulin & Medicare Coverage

The cost of a month's supply of each covered insulin product is currently capped at $35, and people with Medicare don't have to pay a deductible for insulin

- As of January 1, 2023, people enrolled in a Medicare prescription drug plan don't pay more than $35 for a month's supply of each insulin covered by their Medicare prescription drug plan and dispensed at a pharmacy or through a mail-order pharmacy. Also, Part D deductibles no longer apply to the covered insulin product
- As of July 1, 2023, for insulin (delivered through a durable medical equipment pump) covered by Part B and Medicare Advantage Plans
- For a 60- or 90-day supply of insulin, the cost can't be more than $35 for each month's supply of each covered insulin

IRA Provision Timeline

August 16, 2022
Signing of the Inflation Reduction Act

January 1, 2023
No Cost-Sharing Vaccines, Insulin Cap for Part D

July 1, 2023
Insulin Cap for Part B

September 1, 2023
First 10 Medicare Part D drugs selected for the Drug Price Negotiation Program

2024
Elimination of Catastrophic Phase, Expansion of Extra Help

2025
$2000 Part D out-of-pocket cap
15 more Medicare Part D drugs will be selected for negotiation

2026
Medicare Drug Price Negotiation Program continues to select new drugs and make Part B and D drugs available at MFP

The Inflation Reduction Act:

Resources

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Medicare Drug Price Negotiation

Resources are available to help spread the word

MEDICARE DRUG PRICE NEGOTIATION PROGRAM

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In August 2022, President Biden signed the Inflation Reduction Act into law – one of the most consequential health care laws since the Affordable Care Act. The Biden-Harris Administration has made expanding access to high-quality, affordable health care a top priority, and with the Inflation Reduction Act, millions of Americans will see lower health care costs and finally see their prescription drug costs go down.

Key health care provisions of the Inflation Reduction Act include:

Drug Price Negotiation Timeline for 2026

Initial actions for the Medicare Drug Price Negotiation Program:

January 11, 2023

The Centers for Medicare & Medicaid Services (CMS) will release information on how it will engage members of the public (including people with Medicare, consumer advocates, prescription drug companies, Medicare Advantage and Part D plans, health care providers and pharmacies, and other interested parties) on key policies, make requests for information, and inform the public on other implementation timelines and milestones.

Winter 2023

CMS will begin to propose its data collection processes essential to carrying out the first year of the Negotiation Program. These proposals will be available for public input. The first proposal will include a data collection process to gather information necessary to identify

Fact Sheet: Medicare Drug Price Negotiation Program Revised Guidance

MEDICARE DRUG PRICE NEGOTIATION PROGRAM

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In August 2022, President Biden signed the Inflation Reduction Act (IRA) of 2022 (P.L. 117-169) into law. The new law makes improvements to Medicare that will expand benefits, lower drug costs, and improve the sustainability of the Medicare program for generations to come. The law provides meaningful financial relief for millions of people with Medicare by improving access to affordable treatments and strengthening Medicare, both now and in the long run.

For the first time, the law provides Medicare with the ability to directly negotiate the prices of certain high expenditure, single source drugs without generic or biosimilar competition. On March 15, 2023, the Centers for Medicare & Medicaid Services (CMS) issued initial

Q: How will this new program improve Medicare?

Medicare will be able to negotiate directly with drug companies for the price of certain high expenditure drugs covered under Medicare Part D and eventually, Part B, that do not have generic or biosimilar competition. Medicare's new ability to negotiate prices for covered drugs will improve drug affordability for people with Medicare and lower costs for the Medicare program, improving access to innovative, life-saving treatments for people that need them.

Q: How will people with Medicare benefit under the Negotiation Program?

For resources, visit:
https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation

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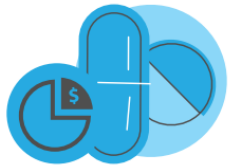
Inflation Rebate Program

Resources are available to help spread the word

- Payment information posted each quarter for Part B rebatable drugs
- The quarterly Average Sales Price (ASP) public files include the coinsurance reductions for certain Part B rebatable drugs
- May change quarterly

Reduced Coinsurance for Certain Part B Rebatable Drugs under the Medicare Prescription Drug Inflation Rebate Program



Applicable July 1-September 30, 2023

President Biden's historic Inflation Reduction Act requires drug companies to pay rebates to Medicare when prescription drug prices increase faster than the rate of inflation for certain drugs furnished to people with Medicare. This new inflation rebate applies to Medicare Part B rebatable drugs, which are single source drugs and biological products, including certain biosimilar biological products, beginning January 1, 2023.

The federal government intends to invoice drug manufacturers for 2023 and 2024 Part B inflation rebates no later than fall 2025. The rebates will be deposited into the Medicare Trust Fund. In addition, beginning April 1, 2023, people with Medicare may see lower out-of-pocket costs for certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the beneficiary coinsurance will be 20% of the inflation-adjusted payment amount, which will be less than what the beneficiary would pay in coinsurance otherwise.

CMS posts payment information each quarter for separately payable Part B drugs, including the Part B rebatable drugs subject to the coinsurance adjustments, in the Medicare Part B Quarterly Sales Pricing (ASP) files, which

For resources, visit…
https://www.cms.gov/inflation-reduction-act-and-medicare/inflation-rebates-medicare

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Making Vaccines More Affordable

Resources are available to help spread the word

Medicare covers more vaccines for free!

Good news! Thanks to a new prescription drug law that went into effect last year, as of January 1, 2023, your Medicare Part D drug plan now covers most vaccines at no cost to you. All adult vaccines recommended by the CDC's Advisory Committee on Immunization Practices are now covered with no out-of-pocket costs. Your Medicare drug plan won't charge you a copayment or apply a deductible for vaccines you get for things like shingles, whooping cough, tetanus, and more.

It's important to stay up to date with vaccines to protect yourself from disease and severe illness. You can also get other vaccines for free with Medicare Part B and Medicare Advantage, such as seasonal flu, COVID-19, and others.

Talk with your doctor about which recommended vaccines are right for you.

Visit Medicare.gov or call 1-800-MEDICARE (1-800- 633-4227) for more information about Medicare coverage and costs.

For resources, visit…
https://www.cms.gov/inflation-reduction-act-and-medicare/resources

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Help with Part D drug costs

Resources are available to help spread the word

Cut your Medicare prescription drug costs with "Extra Help"

Great news: thanks to the new prescription drug law, the Inflation Reduction Act, in 2024 people with Medicare may qualify for even more savings through the Extra Help program. This program helps some people pay their Medicare drug coverage (Part D) costs, like premiums, deductibles, coinsurance, and other costs. In 2024, the program will expand and you may qualify.

How does Extra Help lower my costs?

In 2024, everyone who qualifies for Extra Help will pay:

- $0 for your Medicare drug plan premium.
- $0 for your plan deductible.
- A reduced amount for both generic and brand-name drugs.

For resources, visit https://www.cms.gov/inflation-reduction-act-and-medicare/resources-0
More information on the Extra Help program is available at www.Medicare.gov/ExtraHelp

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Making Insulin More Affordable

Resources are available to help spread the word

For resources, visit…

https://www.medicare.gov/coverage/insulin

https://www.cms.gov/inflation-reduction-act-and-medicare/resources

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What You Can Do

- Share resources and help spread the word on how the prescription drug law helps people with Medicare.
- Share feedback about what additional resources may be helpful to you in your outreach.
- Make sure people are aware and able to take advantage of the benefits.

Partner Resources

- https://lowerdrugcosts.gov
- https://www.cms.gov/inflation-reduction-act-and-medicare
- https://www.cms.gov/inflation-reduction-act-and-medicare/resources-0
- CMS Newsroom (www.cms.gov/newsroom)

Key Things to Remember

- Medicare-covered insulin available at $35 for each month supply for covered insulin and no deductible is effective now
- Access to ACIP-recommended adult vaccines without cost-sharing and no deductible is effective now.
- People with Original Medicare and Medicare Advantage may, depending on their coverage, pay a lower coinsurance amount for certain Part B drugs with price increases higher than inflation since April 1, 2023.
- The new drug law expands eligibility for the full low-income subsidy benefit—known as the Extra Help program—to individuals with limited resources and incomes up to 150% of the federal poverty level beginning January 1st, 2024.

Hospital Price Transparency: What Hospitals Need to Know

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Hospital Price Transparency Regulation Introduction

- The Hospital Price Transparency regulation 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.

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

As a comprehensive machine-readable file (MRF) with all standard charges for all items and services

AND

As a display of standard charges for 300 shoppable services in a consumer-friendly format

CY 2024 OPPS/ASC Final Rule Regulatory Updates

CMS finalized new Hospital Price Transparency requirements in the CY 2024 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule. These new requirements include:

January 1, 2024

Improving Access to Hospital Machine-Readable Files (MRFs): Hospital websites must include a TXT file in the root folder with MRF and contact information (45 CFR 180.50(d)(6)(i)). Hospitals must place a 'footer' at the bottom of te hospital's homepage that links to the webpage that includes the machine-readable file (45 CFR 180.50(d)(6)(ii)).

July 1, 2024

New Data Elements and Format Standardization:

- Hospital MRFs must conform to the CMS template layout and data specifications (180.50(c)(2)).
- Expanded set of data elements including, as applicable: hospital and MRF information, each type of standard charge (including payer-specific negotiated charges by payer and plan), item/service description, relevant billing codes (180.50(b)(2)).
- Hospital must affirm that it has included all applicable standard charge information in the MRF and that the information encoded is true, accurate, and complete (180.50(a)(3)(ii)).

January 1, 2025

Additional Required Data Elements: Hospitals must encode additional new data elements including: 'Estimated Allowed Amount', 'Drug Unit of Measurement', 'Drug Type of Measurement', and 'Modifiers'.

New Requirements to Use a CMS Template Layout and Encode Hospital Standard Charge Information

- As of July 1, 2024, hospitals' MRF must conform to a CMS template layout, data specifications, and data dictionary.

- CMS has made the CMS template available in three non-proprietary formats: CSV "tall", CSV "wide", and JSON.

- CMS has created a GitHub repository to house the required CMS templates, and provides the data dictionary, or technical instruction, on how hospitals must encode standard charge information into machine-readable files.

The CMS Hospital Price Transparency - Data Dictionary GitHub repository is available here https://github.com/CMSgov/hospital-price-transparency.

CMS Templates and Data Dictionary are in CMS GitHub

The CMS GitHub Repository:

- Is a website used by CMS to store CMS templates and data dictionary technical instructions that your hospital must use to create its MRF.
- Provides assistance for technical questions you may have.
- Also makes available voluntary tools (such as a .txt generator) to help your hospital comply with hospital price transparency regulatory requirements.

Hospital Price Transparency Tools

The Centers for Medicare and Medicaid Services (CMS) has developed and maintains tools to support hospitals in meeting some of the machine-readable file (MRF) requirements for Hospital Price Transparency.

The **online validator** tests machine readable files against the required CMS template layouts and data specifications (45 CFR 180.50(c)(2)). The online validator runs in a user's web browser, and it is recommended for nontechnical users.

The **command-line interface (CLI) validator** tests machine readable files against the required CMS template layouts and data specifications (45 CFR 180.50(c)(2)). The CLI is a downloaded tool that runs locally in the user's terminal, and it is recommended for technically proficient users validating multiple files simultaneously or integrating the validator into a software pipeline.

The **MRF naming wizard** assists users in generating the MRF file name in accordance with the naming convention requirements (45 CFR 180.50(d)(5)).

The **TXT file generator** assists users in generating a TXT file with the required attributes of information to improve accessibility to MRFs (45 CFR 180.50 (d)(6)(i)).

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

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.

For all other questions regarding Hospital Price Transparency, email the hospital price transparency team.

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 below or use the QR code. Your answers will help us improve our collaboration with you.

Activity Name: " 6 – CMS Dallas –Louisiana Rural Health Workshop"

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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Questions/Comments

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