Centers for Medicare & Medicaid Services
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Jonathan Blanar: Good afternoon and good morning to those out West. My name is Jonathan Blanar, and I am the Deputy Group Director for the Partner Relations Group in the Office of Communications at CMS. I want to welcome you to our June National Medicare Education Program meeting today. Thank you for joining us this afternoon for presentations on a number of topics. You can see the agenda on the screen. We are going to start off with a presentation from Lauren Shaham, Senior Advisor in the Integrated Communications Management Staff Group in the Office of Communications, who will present the Inflation Reduction Act Outreach and Education Resources. That will be followed by Chuck Nethery, Program Manager, Web & Emerging Technologies Group, Division of Web Development in the Office of Communications here at CMS, who will provide updates on eMedicare and Medicare Plan Finder. Then Kelly Dinicolo, who is also a Senior Advisor here in the Office of Communications at CMS, will give updates on the COVID-19 Public Health Emergency. Finally, we will hear from Emily Yoder, who is a Technical Advisor at the Center for Medicare, who will provide updates on telehealth provisions under Medicare Part B as a result of the end of the COVID-19 Public Health Emergency. Tamika Williams in the Partner Relations Group here at CMS is going to moderate a question-and-answer after each session.

Before we begin, I have a few housekeeping items I wanted to go over. For those who need closed captioning, the instructions and a link are located in the chat function of this webinar. This call is off the record and is for informational and planning purposes only and is being recorded as well. While members of the press are welcome to attend the call, we ask that they please refrain from asking questions. All press/media questions can be submitted using our Media Inquiries Form, which may be found at cms.gov/newsroom/media-inquiries.

We welcome your questions after each presentation. You can enter them in the chat function at the bottom of your Zoom screen. We will be only answering questions relating to today's presentations. We'll do our best to get to as many questions as possible. With that, I'm delighted to introduce our first speaker, Lauren Shaham, who will provide a walkthrough of IRA resources. Lauren?

Lauren Shaham: Thanks so much, Jonathan, and thank you all for being here today. I'm honored to be able to talk to you about the Inflation Reduction Act, give an update where we are with the legislation and its implementation, and point out some resources we have in place for folks to use for educating people with Medicare and others in the country about the changes that have resulted from the IRA. Next slide, please.

So, let's back up a little and just remind ourselves of what the Inflation Reduction Act is. In August of 2022, President Biden signed the IRA of 2022 into law. This new law makes

improvements to Medicare that will expand benefits, lower drug costs, and improve the sustainability of the Medicare program. 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. Next slide, please.

The Inflation Reduction Act is a complicated piece of legislation—it has lots in there and has a very ambitious implementation timeline. This first slide, and I'll talk about where you can find all of this online, goes over what we did in 2022 between August and the end of the year. Again, it was an ambitious amount but some exciting stuff. Next slide, please.

Here is the to-do list for 2023. Some of this has been completed, we have some important things left to do, and there is a big role for all of you across several of these different pieces, which we'll talk about in a moment. Next slide, please. So, here's how you can help get the word out about these benefits. Next slide. Let's start with the one that's circled, which is Part B insulin caps. Go to the next slide. Sorry, we are moving fast here. As a reminder to all of us again, starting on January 1, people enrolled in a Medicare prescription drug plan or a Part D plan will not pay more than $35 a month for each supply of insulin that's covered by their Part D plan. Now starting July 1, which, believe it or not, is a week from Saturday, people with Medicare who use a pump to receive their insulin, so covered under Part B, like "boy," will also be able to benefit from the $35 a month cap if their plan covers their particular insulin. After they meet the deductible, people with Medicare pay 100 percent for supplies unless they also have Part D. So, it's a little complicated.

Where can you find information to help others understand it? Next slide, please. The first and best stop is always Medicare.gov. Right off the home page is a link to a page with information about the IRA in general. It will then link to more information about insulin. You can see on the screen grab right here where it says lower cost for insulin. Please know that we update this as quickly as we need to, so it is really your reliable source of truth. Next slide. We've also created some sample social media and something we call the 7 Things to Know about Medicare Insulin Costs. These are available at the website at the top of the slide for you to use with your constituencies to help them understand and make sure they are getting these very important savings. Next, please.

Okay. Back to our to-do list. I'd like to talk now for a minute about vaccine cost sharing. Next slide. Starting on January 1, adult vaccines recommended by the Advisory Committee on Immunization Practices, known as ACIP, including the shingles vaccine, are available to people with Medicare Part D at no cost to them. The shingles vaccine is probably the best-known new vaccine covered at no cost. It used to carry a very high co-pay and thus resulted in a very low take-up rate. We feel there's not enough we can do to let people know this one barrier of cost has now been removed to getting this and other vaccines. Next slide. As with insulin, we have resources which are at the link that is on the slide, and we hope you will use them to educate people about how they no longer need to pay for these recommended vaccines. Next slide, please.

Ok, jumping ahead to our 2024 to-do list, I wanted to talk for a few minutes about the Low-Income Subsidy Program and the changes that are coming, which we are going to start educating

folks about now because the implementation is for January 1. Next slide, please. Thank you. We refer to this program as "Extra Help," and individuals with Medicare Part D who have low incomes will benefit from expanded financial help with prescription drug cost-sharing and premiums. The low-income subsidy program, LIS or "Extra Help," will be fully available to certain people with Medicare with limited resources who earn less than 150 percent of the federal poverty level starting in 2024. So, this expands access to that Extra Help program significantly. This has already been a program that is undersubscribed. There are lots of eligible people out there who probably don't know they can apply through their state to get this Extra Help. Again, we've got some tools in place and look forward to partnering with you all to help people recognize that they may qualify and start to explore whether they can get this benefit. Next slide, please. As you saw, with insulin and vaccines, we have Extra Help resources, and the link is right there on the slide. The resources include a sample newsletter article and social media, and we hope you will use those with your constituencies. Also, let us know how people react, and we'll talk a little bit later about getting some input from you about what you need to do this important work. Next slide.

I wanted to take a minute to share some resources we have with you for understanding the IRA. As I said earlier, there's a lot in there, it's complicated, and it's happening quickly. There are some resources on our website that can be helpful for you to understand. Next slide. We have a section of cms.gov dedicated to the Inflation Reduction Act, and the address is on the slide. Every time we have an announcement related to any Medicare related piece of the IRA implementation, which is the vast majority of it, this section of the site is updated. So, you may want to bookmark it, and it will be linked from almost every press release or listserv announcement we put out. Next.

Lest you think I'm a fabulous graphic designer, I am not. The timeline pieces I showed you earlier were drawn from our full IRA implementation timeline, which is available on the website at the address noted. If you're not sure where we are or what's up with which benefit, it breaks it out by year and by topic, so it's a good resource for you to understand the trajectory that we are on. Next slide, please.

I think, as we all know, a very big piece of IRA implementation is Drug Price Negotiation. This has its own timeline of milestones, again, a very ambitious one. We are very dedicated to transparency here, so we have a timeline for the different milestones that need to be met in order to implement the Drug Price Negotiation and the resulting change in prices that are coming in 2026. So, this can be a resource to help you understand when we are putting out a different announcement, what it means, and where it fits in the line. Next slide, please.

And the materials that I showed earlier are available on our partner education page. The address is right there. That's another resource for you. We will be adding and updating as things change and we hear more about what you need. So, please take a look there. Then thank you, last slide, please. Thank you—and an ask, which is if you have ideas for tools that would help you educate people about the different IRA benefits and changes and would be willing to, please drop your e-mail in the chat, and we'll be back in touch to talk to you. We are really seeking your guidance about what are the right tools, what will be most helpful, and what you are most likely to use.

Again, if you're willing to drop your e-mail in the chat and we'll be in touch. Thank you for your time and for the work you do to help people with Medicare. I'm delighted to take your questions.

Tamika Williams: We have one question for you. In regard to the Extra Help, Rebecca would like to know, will there be a printable application available for this?

Lauren Shaham: Great question. I don't know the exact answer, but my understanding is that people have to apply through their state. So that's many different printable forms as it were. Let me take that back to the team and we can be back in touch.

Tamika Williams: Thanks, Lauren. We have one more question. Actually, they said the application is through Social Security. Okay.

Lauren Shaham: Okay. We'll figure out the chat thing.

Tamika Williams: Thank you so much, Lauren. At this time, we'll turn it over to Chuck, who will be giving a presentation on eMedicare/Medicare Plan Finder updates.

Chuck Nethery: Thank you so much, Tamika. My name is Chuck Nethery, and I'm the Program Manager for the medicare.gov website and its supporting web applications, or what we call eMedicare. I'll be reviewing some updates today that the eMedicare team will be making this year. Next slide, please.

As Lauren mentioned earlier, the Inflation Reduction Act was a very ambitious and complex piece of legislation. But I am happy to tell everyone that we will be displaying all the Inflation Reduction Act provisions on Medicare Plan Finder for 2024 plans. All those provisions Lauren went over, including the Part D co-pay cap for IRA drugs, Part B coinsurance cap, $0 catastrophic phase cost sharing, $0 out-of-pocket costs for ACIP recommended vaccines, and as Lauren talked about with the Extra Help or Low-Income Subsidy, elimination of that partial status in favor of a full subsidy status. Now, since we are going to be able to display all the IRA provisions for 2024, we'll remove all the help content currently in place for 2023 plans. As a reminder, the 2024 plans will be available on Plan Finder for preview on October 1 and enrollment on October 15. 2023 plans will continue to display as they do today. Next slide, please.

One of the things we try to do is constantly analyze consumer feedback and perform consumer research on Plan Finder so we can identify areas of concern for our beneficiaries. We also want to personalize the eMedicare experience where we can so we can provide beneficiaries with a more meaningful experience. As a result of that feedback and research, we have two major Plan Finder improvements we're working on this year. The summary page redesign will improve the display of the summary page and make it easier to see the enrollment options. We're also making improvements targeted at beneficiaries that are brand new to Medicare. What we are going to do is provide them with a short screener and some alerts to inform them about key deadlines and penalties. The cool thing is that this information will only be displayed for beneficiaries that are new to Medicare. Next slide, please.

On the medicare.gov website, we're looking to make improvements to the Get Started process. We'll be resigning the Get Started landing page and providing users with tailored enrollment steps for their specific situation. We're also working very closely with the Social Security Administration. As you know, and as mentioned in the chat, the process of signing up for Medicare often involves going to both medicare.gov and ssa.gov, and we're looking to smooth out those transition points and make it easier for our users to understand the process. Then, we're also making some improvements across the medicare.gov site. We're working to increase performance and reduce page load times so our visitors have a faster experience and can find what they need more quickly. We're also making some smaller incremental updates to site navigation and layout to make it easier for users to find what they need.

We're also looking to improve the login experience for our Medicare beneficiaries. We will be streamlining various account help flows into a single flow. Right now, there's currently four different flows for things like forgot password and forgot username, and we're migrating that so there's one place people need to go. So, anyone that's having difficulty logging in, they'll just have one place to go for everything. We've also had some really good success with the multi-factor authentication rollout. This year, we're going to make that option to sign up for multi-factor more visible to users. However, we'll still make it voluntary. We have no plans to make multi-factor authentication a mandatory thing. But we've seen a lot more people signing up than we anticipated, and people are even opting in by going to their account settings page and opting in there. So, the goal here is to make it more visible to people, not to force them.

That is all for the high-level updates I have for eMedicare. I will be happy to take any questions.

Tamika Williams: Thanks, Chuck. We do have a question. Will there be any improvements to the printing capabilities in the near future?

Chuck Nethery: Yes, we're constantly making it better. Unfortunately, it's a little difficult because, as you folks know, different browsers print differently, and it's difficult to get things 100 percent consistent across all browsers. I also know there's a bug right now that the team is working on. There's a one-off weird issue with certain plans that are not printing, and it's erroring out. The team is digging into that right now during this sprint and trying to get that resolved so we can make sure this is on the plan details page and make sure that can get fixed. We're always looking to make improvements to the print layout and do things like remove white space and have fewer pages print. Tamika, sorry, I think you're muted.

Tamika Williams: Sorry about that. This question comes from Rebecca—is there going to be an ability to turn on and turn off the low-income selections for counselors helping individuals who may not know if they have Extra Help or MSP?

Chuck Nethery: That is something we've talked about before and something we're looking to do. Unfortunately, I can't give you a date, and I can't give you a promise for this Open Enrollment. But that is a feature that we are looking to add. Not just that, but a couple of other features that would help what we call our power users, folks like the Ship Community, that are really helping a number of beneficiaries walk through the process. That's one of the ideas that we're definitely looking at, so stay tuned.

Tamika Williams: We have one more question, Chuck. Will there be a simplified mobile page for smart phones?

Chuck Nethery: Everything we do across eMedicare, including Plan Finder, we design everything with a mobile first approach. You'll notice if you look at any page, whether it's Plan Finder or medicare.gov, it looks different on a mobile device than it would look like on a desktop. Things like images shrinking or disappearing, making content easier to read on a smartphone, that's built into the design system we use on the site, and we use that across everything on medicare.gov. The one problem is that Plan Finder, unfortunately, is a relatively complex application. If you're using a tablet, it's easy to use, but on a smartphone, it's more difficult to use because it's complicated. We've done a whole lot of things to make that process as easy as possible, and we do have something—I think the last analytics I saw was 15 to 20 percent are actually completing applications on smartphones, so we know folks are able to use it, but we're going to continue to try to improve that process as well.

Tamika Williams: Perfect. I think those are all the questions in regard to your presentation. We're going to move to the next presenter, Kelly Dinicolo, who is giving us a presentation on the end of COVID-19 Public Health Emergency updates. Kelly?

Kelly Dinicolo: I want to thank you for having me here today. We're really excited that we are finally at a place where it's the end of the Public Health Emergency and want to thank all of you who helped us through this period by providing information to Medicare beneficiaries and their caregivers. Next slide, please.

In preparing for the end of the Public Health Emergency, there were several announcements made. CMS used a combination of efforts throughout the period of the Public Health Emergency in order to make decisions that ensured people got the care they needed and that health care providers had the flexibility needed to provide care and respond accordingly while also keeping people safe. Many of the waivers we instituted were put in place to address the acute and extraordinary circumstances during the PHE and were never meant to be a permanent substitution, if you will, for normalcy. Next slide, please. So, during this time, we wanted to keep patients at the center of our care. We paid particular attention to our minority population and, in particular, thought about people in rural communities and how we might ensure care continued for them. Next slide, please. This is a very high-level overview. I'm not going to go through it in detail, but it gives you an example of some of the waivers and flexibilities that were implemented throughout the COVID-19 PHE and kind of forecasts when some of them will be ending, and I know Emily will speak to you later about telehealth flexibilities, but you'll see that many of our waivers for COVID-19 continue through December of 2024. Next slide, please.

One of the programs that seemed to be really successful was the Acute Hospital Care at Home Program. The Consolidated Appropriations Act actually gave an extension to continue this Hospital at Home Initiative and it's been extended through December 31 of next year, 2024. It's an expansion of what you may have heard previously called CMS' Hospital Without Walls, which was first launched in March 2020 as a part of a comprehensive effort to increase hospital capacity and maximize resources during the Public Health Emergency. These flexibilities

allowed providers to save on logistical care for eligible patients by providing the same type of care they would receive in hospitals but at their homes—and included updating staffing flexibilities designed to allow ambulatory surgical centers to provide greater inpatient care where and when needed. The CMS reporting requirements for hospitals and critical access hospitals to report data to the CDC's National Healthcare Patient Safety Network, which is known as NHSN, that's continuing through April 30 of, 2024. The reporting may be reduced from current elements and from daily reporting to a much lesser frequency. Next slide, please.

This is probably the area you're most interested in, which is Medicare and vaccines and testing and treatment for COVID-19 specifically. I want to emphasize that people with Medicare coverage will continue to have access to the COVID-19 vaccination without out-of-pocket cost when going after the end of the PHE. Once the federal government is no longer purchasing or distributing COVID-19 vaccines, people with original Medicare will continue to pay nothing for a COVID-19 vaccination if their doctor or another qualified healthcare provider accepts Medicare assignment for giving the shot. Cost-sharing for COVID-19 vaccines may change for people with Medicare and Medicare Advantage plans. Additionally, testing, people with Medicare can continue to receive the COVID-19 PCR antigen tests with no cost-sharing as long as the test is ordered by a physician or other healthcare provider, like a nurse practitioner and registered nurse or a physician assistant, and the test is performed in a laboratory. People enrolled in a Medicare Advantage plan can continue to receive those same tests covered by Medicare, but their cost-sharing may change throughout the end of the PHE. By law, Medicare does not generally cover over-the-counter services and tests, so that's why the tests many of you purchased at your local drug store or got for free if you had Medicare are no longer covered. Some Medicare Advantage plans may continue to provide this as a supplemental benefit. There's no change in the Medicare coverage of treatments for anyone exposed to COVID-19, and in cases where cost-sharing deductibles apply, they will continue to apply. And then finally, with treatment, that continues beyond the end of the Public Health Emergency. Next slide, please.

As a result of the American Rescue Plan of 2021, states must provide Medicaid and CHIP coverage without cost-sharing for COVID-19 vaccinations, testing, and treatment through the last day of the first calendar quarter that begins one year to the last day of the COVID-19 PHE. With the COVID-19 PHE, since that ended on May 11, 2023, this coverage requirement will end on September 30 of next year. After that date, many Medicaid and CHIP enrollees will continue to have coverage for COVID-19 vaccinations. After the coverage requirements expire, Medicaid and CHIP coverage of COVID-19 treatment and testing may vary by state. Additionally, 18 states and the U.S. territories have opted to provide Medicaid coverage to uninsured individuals for COVID-19 vaccinations, testing, and treatment. Under federal law, Medicaid coverage of COVID-19 vaccinations, testing, and treatment for that group would end when the PHE ended. Next slide, please. With private insurance, vaccines will continue to be covered. Again, testing varies by the health plan a person is enrolled in, but treatments will continue as they are currently covered. Next slide, please.

I wanted to point out some resources that are available to you if you need additional information about some of the specific waivers and flexibilities that we have. All of these can be found on the CMS emergency page. So, if you go to cms.gov and click on CMS emergencies, it will take you to the emergency page, and then you click on past CMS emergencies, and that's where you'll find

most of this. A couple of really useful resources are What Do I Need to Know? CMS Waivers, Flexibilities, and the Transition Forward. That is a very high-level overview of the various waivers and flexibilities that we put in place, with a summary of when they ended or when they will end. That is all I have for you today. I am happy to take any questions you have. I'm going to pass it back to Tamika.

Tamika Williams: Thanks, Kelly. It looks like we don't have any questions for you at this time. If we get any questions, I'll be sure to get them to you to get them answered. Okay. So, we're going to move to our next presenter, Emily, who will be presenting on the end of the COVID-19 Public Health Emergency Telehealth Provisions. Emily?

Emily Yoder: Thanks, Tamika. Hi, everyone, I am Emily Yoder. I am a Technical Advisor in the Division of Outpatient Care in the Centers for Medicare, and I'm going to cover some of the updates to Medicare telehealth now that the Public Health Emergency has ended. Next slide, please.

First, I'm going to describe the non, or rather the pre-PHE policies for Medicare telehealth. I realize these rules have not been really relevant for the past three years because of the pandemic-specific flexibilities. But these policies, as I'll cover in a minute, will go back into effect after the end of 2024. Basically, Section 1834(m) of the Social Security Act outlines the circumstances under which Medicare will pay for services that are ordinarily furnished in person when they are provided in full using telecommunications technology. Basically, 1834(m) lays out the geographic, site of service, and practitioner type restrictions. It also requires that the Secretary establish a process for updating the list of specific services that can be provided via Medicare telehealth, and for that, we use the Physician Fee Schedule (PFS) annual rulemaking process. Generally, the PFS proposed rule is issued sometime in late June or early July, and then the final rule is published by November 1. Next slide, please.

So, in terms of the specific rules, the beneficiary has to be in a rural area and also has to be in a medical facility. In most instances the beneficiary's home is not an eligible originating site for Medicare telehealth. There are some exceptions to that for mental and behavioral health services—the beneficiary can be in a rural or urban area and can be in their home to receive those services via Medicare telehealth. The technology must be interactive, with the exception of federal telemedicine demonstration projects in Alaska and Hawaii, which allow for asynchronous or store-and-forward technology. Next slide, please. During the Public Health Emergency, we used waiver authority to waive those statutory restrictions I just discussed, and also, we used emergency rulemaking to allow telehealth to be provided in the widest range of circumstances.

For the post-PHE telehealth landscape, Congress did take action to make some of the PHE-specific flexibilities permanent. For example, as I said earlier, the Consolidated Appropriations Act of 2021 permanently updated the statute to allow for mental and behavioral health services to be provided to beneficiaries in their homes in all areas, not just rural areas. CAA 2023 extended the rest of the pandemic-specific policies, allowing telehealth to be provided to beneficiaries in rural and urban areas, allowing certain practitioners who are not otherwise able to bill for Medicare telehealth to continue to provide Medicare telehealth and to allow beneficiaries to be in their homes. All of those things were extended until the end of 2024.

The CAA 2023 also permanently authorizes mental health counselors to serve as distant site practitioners. Next slide, please.

We have also made updates to our policies through our notice and comment rule-making process. In the CY 2022 Physician Fee Schedule, we revised our definition of telecommunications technology to include the use of audio-only communication technology for mental health services furnished to beneficiaries in their home. The CAA 2021 also requires periodic in-person visits. In the legislation, it says the beneficiary has to be seen within six months of the initial telehealth, mental health service and then leave it up to the Secretary to determine a window of time that will be appropriate following that initial six months. So, we finalized a requirement that they must be seen once every 12 months with the option of documenting exceptions in the beneficiary's medical record for instances when it would be too burdensome for them to travel for an in-person visit. These in-person requirements have also been delayed by Congress and will not go into effect until after the end of 2024. We're also exercising enforcement discretion on a number of other flexibilities, such as required in-person visits for beneficiaries receiving certain types of visits, like nursing facility visits, and I believe that enforcement discretion isn't until the end of 2023. Next slide, please.

Finally, we have a handful of other policies that pertain to payment for virtual services that are not considered to be Medicare telehealth services. These types of virtual services pertain to things like hospitals and also, rural health clinics, Federally Qualified Health Centers (FQHC), and Opioid Treatment Programs. For example, we are temporarily allowing the definition of direct supervision to include the virtual presence of the supervising practitioner until the end of 2023. In the CY 2023 Hospital Outpatient Prospective Payment System rule, we finalized a policy to permanently pay hospitals for mental health services when those services are furnished to beneficiaries in their homes through communication technology. We actually created hospital-specific coding to describe those services. For FQHCs, we have permanently defined mental health visits to include the presence of the beneficiary via communication technology, both two-way audio/video or audio only. We are allowing OTP intake add-on codes to be furnished via two-way audio/video technology when billed for the initiation of treatment with buprenorphine. Next slide, please.

That is all I have, and I'm happy to answer whatever questions that you might have.

Tamika Williams: Thank you. It looks like we don't. I think Kelly's responding to one question right now. We don't have any other questions at this time. Thank you for the presentation.

Emily Yoder: Thank you for having me.

Tamika Williams: No problem. This concludes our presentation for today. We appreciate all of you for taking the time to be with us today. If you have any information or topic suggestions for future meetings or questions about Medicare in general, submit them to our partnership mailbox. It's partnership@cms.hhs.gov. Again, that's partnership@cms.hhs.gov. Thank you so much and have a great day.