CMS Coverage Options

Indian Health Service Partnership Conference

August 2023

Discussion Points

I. Medicaid

II. Marketplace

III. Medicare

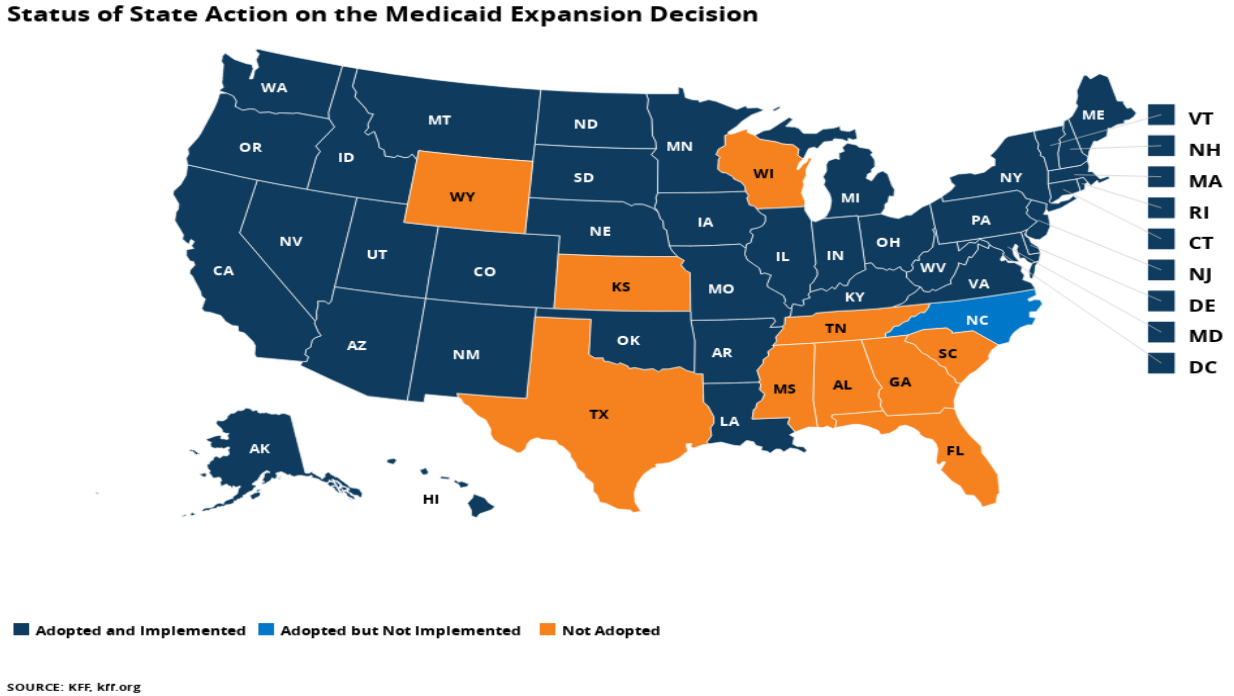
I. Medicaid

- Medicaid eligibility covers different low-income populations.
- Generally Medicaid eligibility covers the following groups:
  - Children
  - Pregnant Women
  - Families
  - Individuals with Disabilities
  - Elderly needing long term support services
  - The Medicaid Expansion population: Childless Adults ages 19-64
  - Visit Medicaid.gov/medicaid/eligibility/index.html for more information about Medicaid eligibility.
  - Also, visit Medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/list-of-eligibility-groups.pdf to view the list of eligibility groups.

Medicaid: Expansion

- States have the option to extend Medicaid coverage to low-income adults (ages 19 to 64) with incomes up to 138% of the FPL
- States decide when to expand and there is no deadline for state decision
- On July 1, 2023, South Dakota expanded Medicaid to 52,000 individuals, including an estimated 27,000 tribal members.
- As of August 2023, 41 states, including DC, have expanded Medicaid.

Status of Medicaid Expansion Decisions



Currently 41 states including DC have expanded. SD implemented expansion on July 1. NC has passed legislation and expansion is contingent upon SFY 2023-2024 budget appropriations. 10 states have not expanded to date.

Streamlined Application

- One application for Marketplace health plans, Medicaid, and CHIP
  - Premium tax credits and cost sharing reductions
  - Online, by phone, by mail, or in person
- May be able to enroll immediately once eligibility determination is complete
  - Depending on the program for which the applicant is eligible
- You can apply for Medicaid and CHIP at any time
  - At HealthCare.gov, or
  - Through your state agency

Streamlined Application

- Question: **Are you or is anyone in your family American Indian or Alaska Native?**
- **YES. If yes,** go to Appendix B.

Streamlined Application

- Appendix B
  - Information is requested to assure that cost sharing exemptions and income and resources are counted properly for AI/AN.
  - Asks AI/AN individual's relationship with Indian Health Care Providers.
  - Asks about certain AI/AN Income/Resources that are countable for the Marketplace but not countable for Medicaid.

Medicaid: **“four walls” grace period**

- On January 15, 2021, CMS issued an Informational Bulletin extending the “four walls” grace period previously granted to IHS and Tribal facilities from January 30, 2021 to October 31, 2021. On October 4, 2021, CMS extended the grace period to nine months after the Public Health Emergency ends.

- On June 30, 2023, CMS announced plans to further extend the grace period by one year until February 2025. A CMS Medicaid Informational Bulletin will be released soon.

- The extension of the grace period permits IHS and Tribal clinics to continue to claim Medicaid reimbursement at the IHS All Inclusive Rate (AIR) for services provided outside of the “four walls” of the clinic.

- The “four walls” requirement applies only to free-standing clinics. Other facilities, including FQHCs, hospital outpatient clinics, home health agencies, etc. are not subject to this limitation.

- CMS is exploratory regulatory options to amend the clinic benefit regulations to possibly exempt certain clinics from the four walls requirements.

Medicaid and CHIP: AI/AN Cost Sharing Protections

AI/ANs have the following Medicaid and CHIP protections:

- Do not have to pay premiums or enrollment fees
- No cost sharing for AI/ANs enrolled in CHIP.
- No cost sharing in Medicaid if the beneficiary has ever used an Indian health care provider, or received services through Purchased/Referred Care.

Medicaid: Cost Sharing Protections

- Payments for Medicaid that are **NOT** cost sharing (and not exempted):
  - Medically Needy Spend-down.
  - Post Eligibility Treatment of Income (PETI)

Medicaid and CHIP: Indian Trust Income and Resource Protections

Certain types of Indian income and resources are not counted when determining Medicaid or CHIP eligibility:

- Per capita payments from a Tribe that come from natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or profits from Indian trust land (including reservations and former reservations).
- Money from selling things that have Tribal cultural significance, such as Indian jewelry or beadwork.

Medicaid: AI/AN Estate Recovery Protections

Types of property exempt from Medicaid estate recovery action:

- Property located on a reservation or within the most recent boundaries of a reservation including:
  - Real property and improvements
  - Ownership interest in:
    - Rents
    - Leases
    - Royalties
    - Usage rights
- For use of:
  - Natural resources
  - Fish/shellfish
  - Harvesting animals
  - Harvesting plants or timber

Medicaid: AI/AN Estate Recovery Protections

- Items with religious, spiritual, traditional or cultural significance or used to support subsistence or a traditional lifestyle according to tribal law or custom.

- Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights in listed properties, as long as they can be clearly identified as such.

Resuming Normal Eligibility and Enrollment Operations

- **Beginning April 2023, states will resume normal operations,** including **restarting** full Medicaid and CHIP eligibility renewals and **ending coverage for individuals no longer eligible for Medicaid/CHIP –** a process known as “unwinding.”

- States will need to **address a significant volume of pending renewals** and other actions. This is likely to **place a heavy burden** on the state workforce and existing processes and **increase the risk** that individuals lose health coverage.

- According to some estimates, when states resume 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.

- The Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) are **working closely with states now** to ensure that they are ready when unwinding begins; **eligible enrollees retain coverage** by renewing their Medicaid or CHIP; and **enrollees eligible for other sources of coverage,** including through the Marketplace, smoothly transition.

[1]Available at: https://www.urban.org/research/publication/what-will-happen-medicaid-enrollees-health-coverage-after-public-health-emergency

Steps to Take if You Get a Renewal Form From Your State

1. **Read the entire letter!**

2. **Complete your renewal form and send it back**– Fill out the form and return it to your state Medicaid or CHIP program right away to avoid a gap in your Medicaid or CHIP coverage. Include all requested information and supporting documents.

   If you're a parent who is no longer eligible for Medicaid, your child may still be eligible for Medicaid or CHIP. It's important to **always** return the renewal form so your state can determine if you or anyone in your family qualifies for coverage.

3. **Look for follow-up information from your state about your coverage** – State Medicaid and CHIP offices will review information and tell you if your coverage has been renewed. If you're no longer eligible, they'll tell you the date coverage will end.

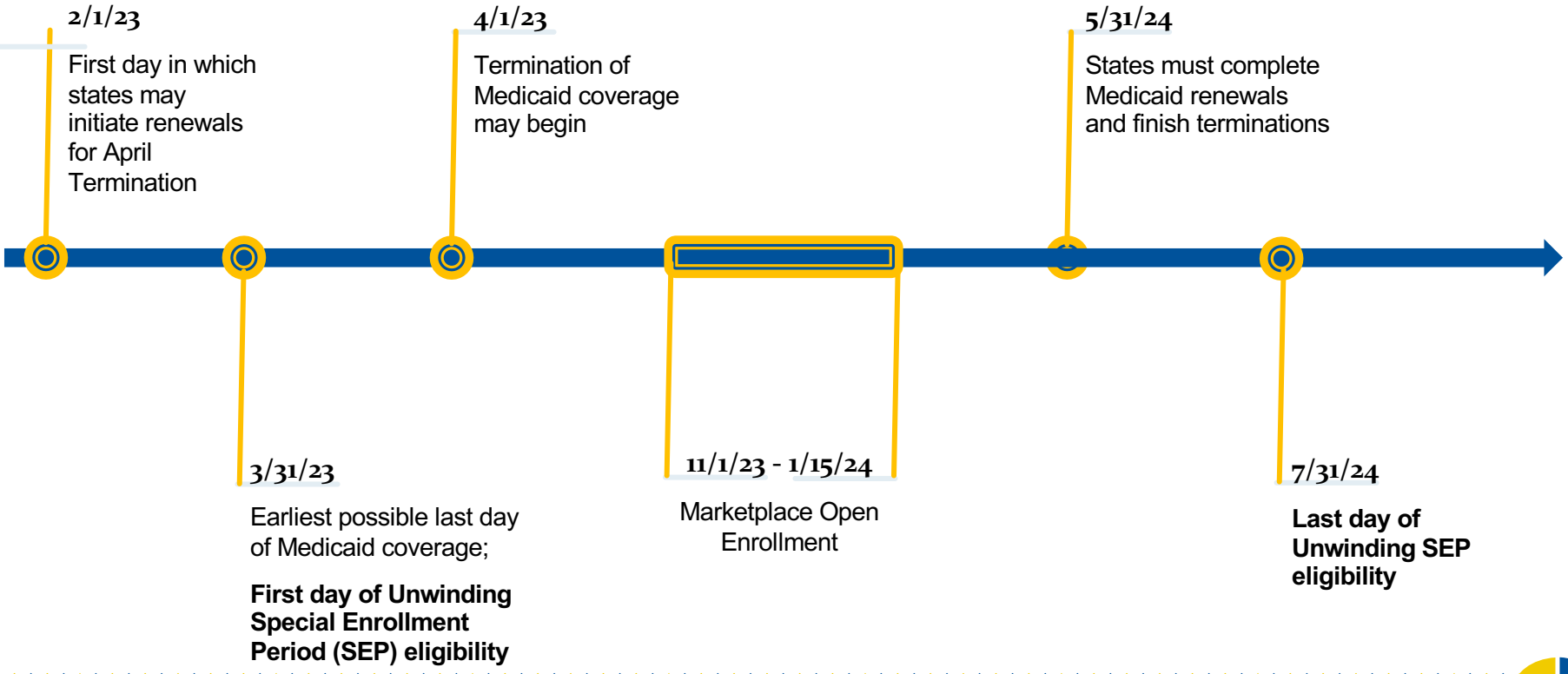
Steps to Take if You've Lost Medicaid or CHIP Coverage

1. **Review the notice from your state to see why you lost Medicaid or CHIP coverage**
   - If the state ended your coverage because they didn't have the necessary information to complete your renewal, you can contact your state to provide the missing information. Find your state's contact information at Medicaid.gov/renewals.
   - If the state ended your coverage because they determined you're no longer eligible, you'll need to find another option for health coverage.
2. **Appeal the decision or re-apply for Medicaid or CHIP**
   - If you think you're still eligible for Medicaid or CHIP and the state wrongly ended your coverage, you can ask the state for a second review and appeal the decision.
   - If there is a change in your situation (like a change in income), you can reapply for Medicaid or CHIP at any time. Visit Medicaid.gov to find out how you can contact your state to re-apply.

Steps to Take if You've Lost Medicaid or CHIP Coverage (continued)

3. **Look at other health coverage options and find the one that is best for you**
   - **The Health Insurance Marketplace** – HealthCare.gov
     - Most people can find a plan for $10 or less per month with financial help.
     - People can qualify for savings on a health plan that lowers the monthly cost.
     - All plans cover doctor visits, prescription drugs, emergency care, and more.
     - You may qualify for a Special Enrollment Period (SEP)
   - **Medicare** – Medicare.gov
     - You may qualify for an SEP to enroll in Medicare without paying a penalty if you missed your initial enrollment period.
   - **Employer-sponsored coverage** – check with your employer
     - You can enroll in an employer plan outside of open enrollment if you recently lost Medicaid or CHIP.

Transition from Medicaid to Marketplace Timeline Increased Assister Support



II. Marketplace

- The Health Insurance Marketplace® provides health plan shopping and enrollment services for individuals and families (the individual market), as well as employees of small businesses [the Small Business Health Operations Program (SHOP)] through websites, call centers, and in-person assistance.

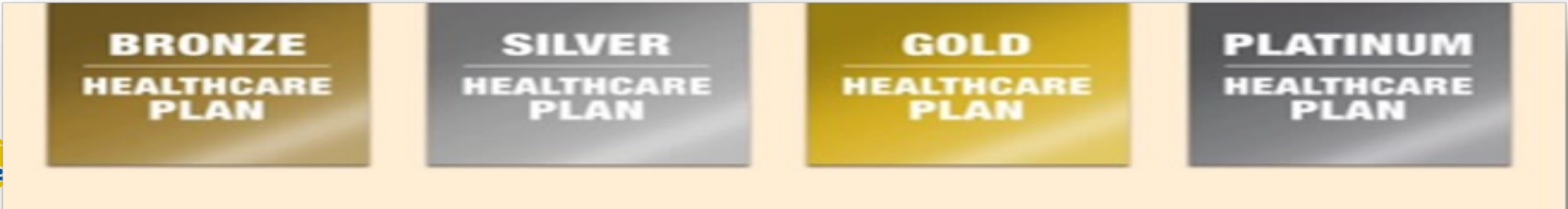
- The Marketplace will determine eligibility for:
  - Coverage in Marketplace plans
  - Advance payments of the premium tax credit (APTC) toward monthly premiums
  - Cost-sharing reductions (CSRs) to lower what consumers pay for out-of-pocket costs, like deductibles, copayments, and coinsurance
  - Medicaid and the Children's Health Insurance Program (CHIP)

Operation of the Marketplaces

- A marketplace can be operated by a state or the Federal Government.
- There are key differences between Marketplace types including:
    1. State-based Marketplace (SBM)
    2. Federally-facilitated Marketplace (FFM)

Health Plan Categories

- Bronze level – a health plan that has an Actuarial Value (AV) of 60 percent (Consumers pay 40 percent of costs on average)
- Silver level – a health plan that has an AV of 70 percent (Consumers pay 30 percent on average)
- Gold level – a health plan that has an AV of 80 percent (Consumers pay 20 percent on average)
- Platinum level – a health plan that has an AV of 90 percent (Consumers pay 10 percent on average)



Who's Eligible for Coverage through the Marketplace

To be eligible for coverage through a Marketplace, individuals and households must:

1. Live in the United States (U.S.) in a state served by the Marketplace where they're applying;

2. Be U.S. citizens, U.S. nationals, or lawfully present immigrants for the entire time they plan to have coverage; and

3. Not be incarcerated (unless pending disposition of charges).

Affordability Program: Premium Tax Credits

- Consumers with certain household incomes who aren't eligible for other qualifying coverage, like through a job, Medicare, most Medicaid coverage, or CHIP, may be eligible for savings through the Marketplace.
- If consumers projected annual household income for the coverage year falls between 100 % and 400 % of the Federal Poverty Level (FPL), they may qualify for a premium tax credit (PTC). Per the Inflation Reduction Act, Congress waived the 400% FPL cap through 2025.

Note:

- PTCs are only available to consumers who enroll in an individual market Marketplace plan through the Marketplace.
- Eligible consumers can use all, some, or none of their PTCs in advance to lower their monthly premiums—these are called advance payments of the premium tax credit (APTC).

Affordability Program: Premium Tax Credits (Cont.)

- Reconciling APTC:
  - The amount of PTC a consumer is eligible for may change throughout the coverage year, if there are changes to the consumer's changes to the consumer's household income, household income, household size, or other determining factors.
  - It's very important that consumers report life changes to the Marketplace.
  - When consumers file their income taxes, they'll have to reconcile any ATPC that were paid on their behalf to reduce their monthly premiums with the amount of PTC they were ultimately eligible for based on their actual annual household income.
- If consumers use APTC in excess of the PTC they are determined eligible for, they may be required to repay all or some of the difference when they file their federal income tax return.
- If consumers use less PTC than they're determined eligible for when they file their federal income tax return, they may receive the difference as a refundable credit.

Cost-Sharing Reductions: Special Benefits for AI/AN Consumers

AI/AN consumers with income between 100 percent to 300 percent of the FPL can enroll in a “zero cost-sharing plan” through the Marketplace and have no out-of-pocket costs – like deductibles, copayments, and coinsurance – when they get care.

AI/AN consumers at any income level can enroll in a “limited cost-sharing plan” through the Marketplace. Under this plan, a referral **will be** required from an Indian health care provider to avoid out-of-pocket costs when they receive essential health benefits from a qualified health plan (QHP).

Limited and zero cost-sharing plans are available to AI/AN consumers in any plan (e.g. bronze, silver, etc.) category.

When to Enroll

- Eligible consumers can enroll in or change Marketplace plans during the annual Open Enrollment Period (OEP) or during a Special Enrollment Period (SEP).
  - Exception: Members of federally recognized Tribes can enroll in the Marketplace or change plans throughout the year, not just during the yearly OEP or during a SEP.
- In the FFM for individuals and families, the OEP starts on November 1 and ends on January 15 the following year.
- In the SHOP Marketplaces, eligible small employers determine their group's annual OEP (for themselves and their eligible employees/dependents).
  - Small employers can generally complete a group enrollment at any point throughout the year.

How to Apply

- **Consumers can apply for Marketplace coverage through**:
  1. HealthCare.gov (English) and CuidadoDeSalud.gov (Spanish)
  2. Directly through some Marketplace plan issuers
  3. The Marketplace Call Center
  4. Marketplace enrollment assisters
  5. Marketplace-registered agents and brokers, or web-broker sites
  6. Paper Application
- Language assistance is available through interpreters, Call Center support, print, and web resources:
  - Help is available to complete an application.
  - Job aids in 33 languages can be found at: Marketplace.CMS.gov/applications-and-forms/individuals-and-families-forms.html.

Marketplace Call Center

Marketplace Call Center:

- Assists consumers in FFMs and SPMs:
  - 1-800-318-2596 (TTY: 1-855-889-4325)
- Customer service representatives are available 24/7
- Help with eligibility, enrollment, and referrals
- Assistance in English and Spanish
- Oral interpretations in 240+ additional languages
- State Based Marketplaces have their own call centers

In-Person Assistance

- In-person assisters may provide face-to-face, one-on-one assistance to applicants and enrollees submitting Marketplace eligibility applications in their FFM service area.
- Marketplace-approved in-person help is available through several programs to help consumers with the process of applying for enrolling in health insurance coverage, including

    1. Navigators
    2. Certified Application Counselors
    3. Agents and Brokers

- Consumers can use the Find Local Help tool (LocalHelp.HealthCare.gov) to search for a list of local people and organizations who can help them apply, pick a plan, and enroll in Marketplace coverage.

Certified Application Counselor Designated Organization (CDO) program-Application Process

CMS invites **new applicant organizations** who want to become a CDO for Plan Year 2024 to apply during CMS's Open Season **August 1-December 15, 2023.**

To apply to become a CDO:

1. Access and complete the CDO application at https://mats.secure.force.com/CDOApplication/. CMS will review your application and send a determination email with your application status. Please allow up to 10 business days for this review.
2. If CMS approves your application, you must access the CDO Organizational Maintenance Web Form (link provided in approval email) and submit a signed CMS-CDO agreement. CMS will then review your signed agreement and send a determination email. If CMS approves your agreement, you will receive a Welcome Packet email with a unique CDO ID. Please allow up to 5 business days for this review.

More Information About the Marketplace

- Sign up to get email and text alerts at HealthCare.gov/subscribe
- Healthcare.gov/Tribal
- Updates and resources for organizations are available at Marketplace.cms.gov
- Twitter@HealthCareGov
- Facebook.com/Healthcare.gov?_rdr=p
- YouTube.com/playlist?list=PLaV7m2-zFKpgZDNCz7rZ3Xx7q2cDmpAm7

III. Medicare

Medicare provided health insurance for people:

- 65 and older
- Under 65 with certain disabilities, like ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) without a waiting period
- Any age with End-Stage Renal Disease (ESRD)

NOTE: To get Medicare you must be a U.S. citizen or lawfully present in the U.S. Must reside in the U.S. for 5 continuous years.

Your Medicare Options

Original Medicare

☑ Part A

☑ Part B

You can add:

☐ Part D

You can also add:

☐ Supplemental coverage

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (also known as Part C)

☑ Part A

☑ Part B

Most plans include:

☑ Part D

☑ Some extra benefits

Some plans also include:

☐ Lower out-of-pocket costs

Automatic Enrollment: Medicare Part A & Part B

Enrollment is automatic for people who get:

- Social Security Benefits
- RRB Benefits

Look for your "Get Ready for Medicare Package"

- Mailed 3 months before:
  - You turn 65
  - 25th month of disability benefits
- Includes your Medicare card

Some People Must Take Action to Enroll in Medicare

To apply for Medicare 3 months before you turn 65, contact Social Security at ssa.gov or 1-800-772-1213; TTY: 1-800-325-0778

If you retired from a railroad, contact your local Railroad Retirement Board at 1-877-772-5772; TTY: 1-312-751-4701

NOTE: The age for full Social Security retirement benefits is increasing. Medicare eligibility age is still 65.

When to Sign Up or Make Changes to Your Medicare Coverage

If you don't already have Medicare:

- Initial Enrollment Period (IEP)
- Special Enrollment Period (SEP) (in certain circumstances)
- General Enrollment Period (GEP)

If you already have Medicare and want to change how you get your coverage:

- Open Enrollment Period (OEP)
- Medicare Advantage OEP
- 5-Star Enrollment Period
- Special Enrollment Period (SEP) (in certain circumstances)

Initial Enrollment Period (IEP) 2023

7-Month Period

If you apply **before** you turn 65, your coverage starts the month you turn 65.

If you apply **during** the month you turn 65, your coverage starts the next month.

If you apply **after** the month you turn 65, your coverage begins 2 or 3 months after you turn 65.

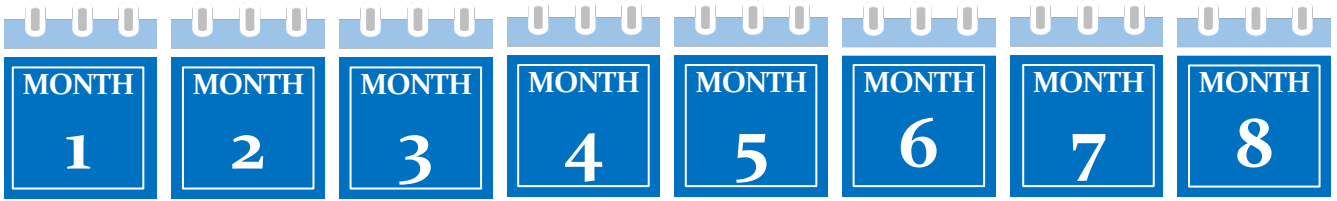
If you enroll after your IEP, you may pay a late enrollment penalty

NOTE: Your 6-month Medigap OEP starts when you're both 65 and have Part B.

Special Enrollment Period (SEP) 2023

Starts after Medicare IEP and having GHP coverage based on current employment

Continues for 8 Months after GHP Coverage Based on Current Employment Ends



You can sign up for Part A (if you have to pay for it) and/or Part B:

- Anytime you're still covered by the GHP
- During the 8-month period that begins the month after the employment ends or the coverage ends

Usually no late enrollment penalties

NOTE: You have 6 months from the Part B effective date to buy a Medigap policy (must have Part A and Part B).

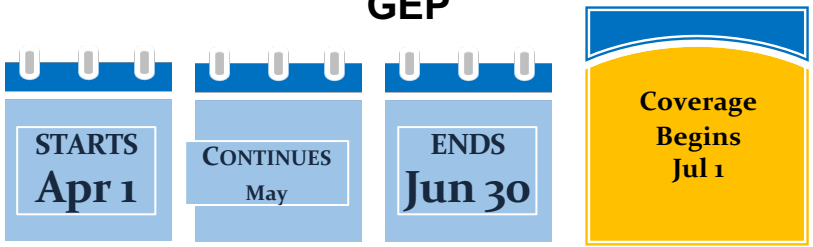
General Enrollment Period (GEP) 2023

3-Month GEP each year

You can sign up for:

- Part A (if you have to buy it)
- Part B

If you enroll in Medicare during the GEP



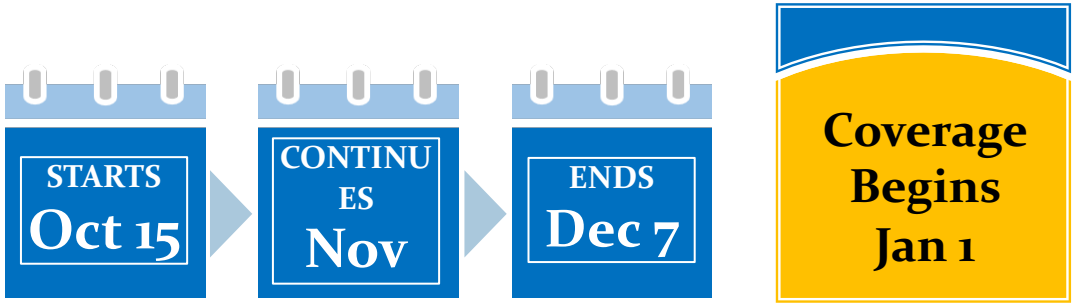
You can enroll in:

- Medicare Advantage Plan
  (if you have Part A and Part B)
- Part D (if you have Part A and/or Part B)

May have late enrollment penalties

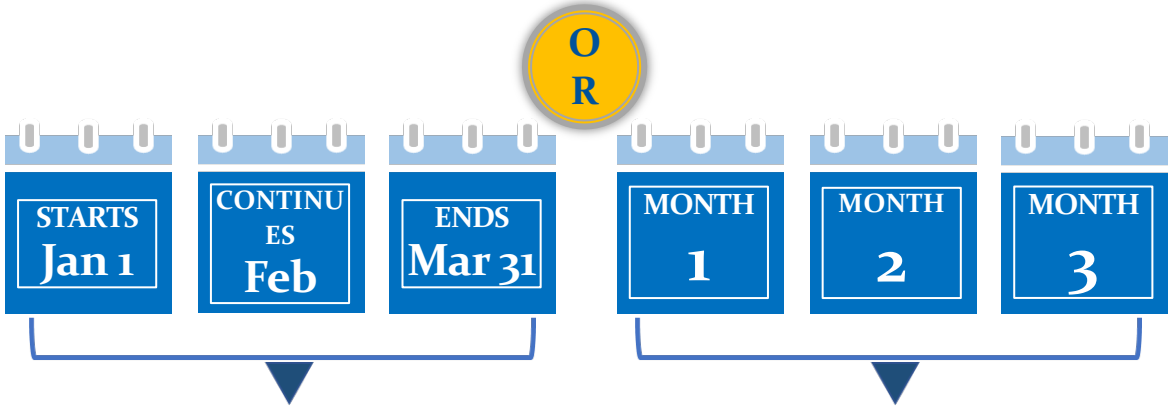
Yearly Open Enrollment Period (OEP) for People with Medicare

7-Week Period



- 7-week period each year where you can enroll in, disenroll, or switch Medicare Advantage Plans or Medicare drug plans
- This is a time to review health and drug plan choices

Medicare Advantage Open Enrollment Period



Annual
Medicare Advantage OEP
January 1—March 31

Newly Eligible
Medicare Advantage OEP
1st 3 months of entitlement to Medicare Part A and Part B

You can:

- Switch to another Medicare Advantage Plan, with or without drug coverage
- Drop your Medicare Advantage Plan and return to Original Medicare. If you do:
  - You can enroll in a Medicare drug plan
  - Coverage begins the 1st of the month after you enroll in the plan

NOTE: You need to be in a Medicare Advantage Plan to use this enrollment period.

Other Medicare Special Enrollment Periods (SEPs)

You may have an SEP if you:

- Move out of your plan's service area
- Enter, live at, or leave a long-term care facility (like a nursing home)
- Are in a plan that leaves Medicare or reduces its service area
- Have Medicaid and Medicare or qualify for a low-income subsidy
- Get, lose, or have a change in dual/LIS-eligibility status
- Leave or lose employer or union coverage
- Are sent a retroactive notice of Medicare entitlement

Part A (Hospital Insurance) Covers

- **Inpatient care in a hospital, including:**
  - Semi-private room
  - Meals
  - General nursing
  - Drugs (including methadone to treat an opioid use disorder)
  - Other hospital services and supplies
- **Inpatient care in a skilled nursing facility (SNF)** after a related 3-day inpatient hospital stay

Part A
Hospital Insurance

Part A (Hospital Insurance) Covers (continued)

Part A helps cover:

- Blood (inpatient)
- Hospice care
- Home health care
- Inpatient care in a religious nonmedical health care institution (RNHCI)

Part A
Hospital Insurance

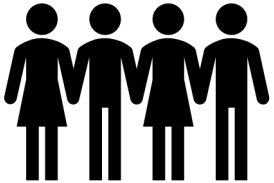
Paying for Part A 2023

Most people don’t pay a premium for Part A, but:

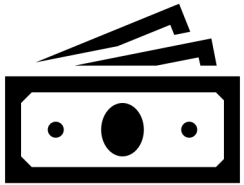
- If you or your spouse paid FICA taxes for at least 10 years, you get Part A without paying a **premium**
- You may have a **penalty** if you don’t enroll when first eligible for Part A (if you have to buy it)
  - Your monthly premium may go up 10%
  - You'll have to pay the higher premium for twice the number of years you could’ve had Part A, but didn’t sign up

Decision: Do I Need to Sign Up for Part A?

Consider:



It's free for most people



You can pay for it if your work history isn't sufficient (there may be a penalty if you delay)

Talk to your benefits administrator if you (or your spouse) are actively working and covered by an employer plan

NOTE: To avoid Internal Revenue Service (IRS) tax penalties, stop contributions to your Health Savings Account (HSA) before Medicare starts.

Medicare Part B (Medical Insurance) Covers

- Doctors' services
- Outpatient medical and surgical services and supplies
- Clinical lab tests
- Durable medical equipment (DME) (like walkers and wheelchairs)
- Diabetic testing equipment and supplies
- Preventive services (like flu shots and a yearly wellness visit)
- Home health care
- Medically necessary outpatient physical and occupational therapy, and speech-language pathology services
- Outpatient mental health care services

What's Not Covered by Part A & Part B?

Some of the items and services that Part A and Part B don't cover include:

- Most dental care
- Vision (for prescription glasses)
- Dentures
- Cosmetic surgery
- Massage therapy
- Routine physical exams
- Hearing aids and exams for fitting them
- Long-term care
- Concierge care
- Covered items or services you get from an opt out doctor or other provider

They may be covered if you have other coverage, like Medicaid or a Medicare Advantage Plan that covers these services.

What You Pay in 2023: Part B Monthly Premiums

Standard premium is $164.90 in 2023

Some people who get Social Security benefits pay less due to the statutory hold harmless provision

Your premium may be higher if you didn't choose Part B when you first became eligible or if your income exceeds a certain threshold

What You Pay in Original Medicare in 2023: Part B

Yearly Deductible	$226 in 2023
Coinsurance for Part B Services	▪ 20% for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for most preventive services ▪ 20% for outpatient mental health services, and copayments for hospital outpatient services

NOTE: If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in the presentation.

Decision: Should I Keep/Sign Up for Part B?

Consider:

- Most people pay a monthly premium
  - Usually deducted from Social Security/RRB benefits
  - Amount depends on income
- Part B may supplement employer coverage
  - Contact your benefits administrator to understand the impact to your employer plan
  - If you don't have other coverage, declining Part B will mean you don't have full coverage
- Sometimes, you must have Part B

When You Must Have Part A & Part B

To buy a Medicare Supplement Insurance (Medigap) policy

To join a Medicare Advantage Plan

Eligible for TRICARE for Life (TFL)

Eligible for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

Employer coverage requires you to have it (has fewer than 20 employees)

How Part D Works

- It's optional
  - You can choose a plan and join
  - May pay a lifetime penalty if you join late

If you join late, you may have a lifetime penalty.

- Plans have formularies (lists of covered drugs), which:
  - Must include range of drugs in each category
  - Are subject to change—you'll be notified
- Your out-of-pocket costs may be less if you use a preferred pharmacy
- If you have limited income and resources, you may get Extra Help

Medicare Drug Plan Costs: What You Pay in 2023

Most people will pay:

- A monthly **premium** (varies by plan and income)
- A yearly **deductible** (if applicable)
- **Copayments or coinsurance**
- **Out-of-pocket** costs
  - A **percentage** of the cost while in the coverage gap, which begins at $4,660 for out-of-pocket spending in 2023
  - **Very little** after spending $7,400 out-of-pocket in 2023--will automatically get catastrophic coverage

Insulin Products & Medicare Coverage

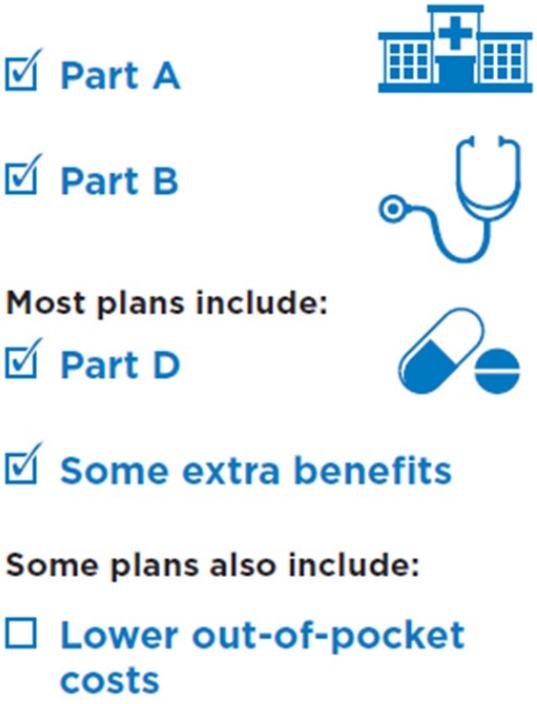
The cost of a month's supply of each covered insulin product is capped at $35, and you don't have to pay a deductible for insulin

- Effective January 1, 2023 for insulin covered by Part D and Medicare Advantage Plans
- Effective July 1, 2023 for insulin covered by Part B (durable medical equipment pump) and Medicare Advantage Plans
- If you get a 60- or 90-day supply of insulin, your costs can't be more than $35 for each month's supply of each covered insulin
- If you use a covered insulin product you can add, drop, or change your Part D coverage one time between now and December 31, 2023
  - If you change plans mid-year, your TrOOP costs will carry over from one plan to the next
  - Call 1-800-MEDICARE if you take insulin and want to change your plan

When Can I Enroll in a Part D Plan? (continued)

What if I'm in a Medicare Advantage Plan on January 1 but switch to Original Medicare?	You may add Medicare drug coverage if you switch during the Medicare Advantage OEP (January 1–March 31).
Can I join, switch, or drop a drug plan if I qualify for a Special Enrollment Period (SEP)?	Yes.
What if I'm new to Medicare and enrolled in a Medicare Advantage Plan during my IEP?	You can make a change within the first 3 months you have Medicare.
When's the 5-star SEP?	December 8–November 30 each year, you can switch to Medicare drug coverage that has 5 stars for its overall rating.

Medicare Advantage Plans (Part C)



- Another way to get your Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) **coverage**
- Offered by Medicare-approved **private companies** that must follow rules set by Medicare
- Most Medicare Advantage Plans include drug coverage (Part D)
- coverage (Part D).In most cases, you'll need to use health care providers who participate in the **plan's network** (some plans offer out-of-network coverage)

Marketing & Communications Oversight Improvements for Plan Year 2023

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

Marketing & Communications Oversight Improvements for Plan Year 2024

MA Organizations can't:

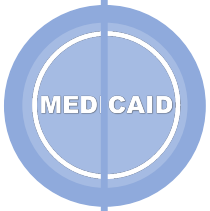
- Advertise benefits that aren't available to beneficiaries in the service area(s) where the marketing appears
- Market any products or plans, benefits, or costs, unless the MA organization or marketing name(s) as listed in HPMS of the entities offering the referenced products or plans, benefits, or costs are identified in the marketing material
- Advertise about savings available that are based on a comparison of typical expenses for uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of person with Medicare

Marketing & Communications Oversight Improvements for Plan Year 2024 (continued)

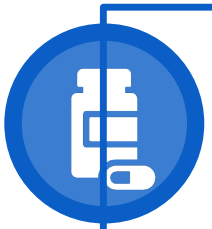
- Ads will be prohibited if they don't mention a specific plan name
- The TPMO disclaimer must add
  - SHIPs as an option for beneficiaries to get additional help
  - Include the number of organizations/plans represented
- MA organizations can't use
  - Superlatives unless a source of documentation/data support language
  - Data older than the prior contract year (must be specifically identified)
  - Use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way.
    - Use of the Medicare card image is permitted only with authorization from CMS

Help for People with Limited Income & Resources

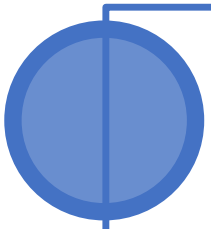
Medicare Savings Programs



Medicaid



Extra Help



CHIP

Minimum Federal Eligibility Requirements for Medicare Savings Programs

Medicare Savings Programs	Individual Monthly Income Limits	Married Couple Income Limits	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$1,153	$1,546	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,379	$1,851	Part B premiums only
Qualifying Individual (QI)	$1,549	$2,080	Part B premiums only
Qualifying Disabled & Working Individuals (QDWI)	$4,615	$6,189	Part A premiums only

- **Resource limits** for QMB, SLMB, and QI are $8,400 for an individual and $12,600 for a married couple.
- **Resource limits** for QDWI are $4,000 for an individual and $6,000 for a married couple.

What's Extra Help?

- Program to help people pay for Medicare drug costs (Part D) (also called the low-income subsidy (LIS))
- If you have the lowest income and resources, you pay no premiums or deductible, and small or no copayments
- If you have slightly higher income and resources, you pay reduced deductible and a little more out of pocket
- No coverage gap or late enrollment penalty if you qualify for Extra Help

NOTE: A Special Enrollment Period (SEP) allows you to change your Medicare drug plan (also known as a PDP) once per quarter in the first 3 quarters of the year

Qualifying for Extra Help

You automatically qualify for Extra Help if you get:

- Full Medicaid coverage
- Supplemental Security Income (SSI)
- Help from Medicaid paying your Medicare premiums (Medicare Savings Programs; sometimes called “partial dual”)

If you don’t automatically qualify you must:

- Apply online at ssa.gov/benefits/medicare/prescriptionhelp.html
- Call Social Security at 1-800-772-1213; TTY: 1-800-325-0778, and ask for the “Application for Help with Medicare Prescription Drug Plan Costs” (SSA-1020)

The CMS COVID-19 Response

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers included:

Telehealth

People with Medicare could get telehealth services from their home, increasing access to care.

Care by Phone

People with Medicare could consult with a doctor, nurse practitioner, psychologist, and others.

Acute Hospital Care at Home (AHCaH)

Hospitals could treat appropriately selected patients with inpatient-level care in their homes.

End of COVID-19 Public Health Emergency (PHE)

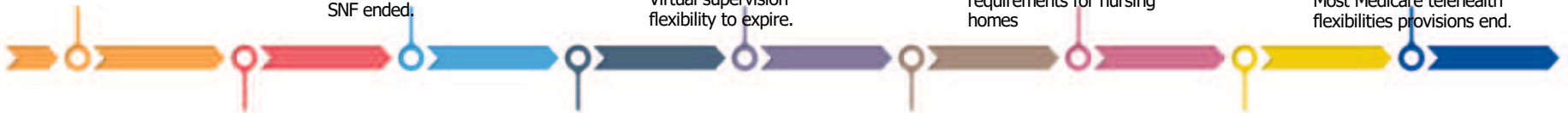
CMS policies changed to address the PHE so the expiration impacts some rules, including:

- Waivers and flexibilities
- Coverage for vaccines, testing, and treatment
- Telehealth and Extension of Medicare Telehealth Flexibilities (Consolidated Appropriations Act (CAA) 2023)
- Coverage Transition (COVID-19 PHE/Unwinding)

End of the COVID-19 PHE Preparations

- CMS used a combination of emergency authority waivers, regulations, enforcement discretion, and sub-regulatory guidance to ensure access to care and give health care providers the flexibilities needed to respond to COVID-19 and help keep people safer
- **Flexibilities**
  - Emergency Interim Regulations
  - Blanket Waivers
  - Sub-regulatory Guidance
- **Many have terminated at the end of the PHE**, as they were intended to address the acute and extraordinary circumstances of a rapidly evolving pandemic and not replace existing requirements

Waivers & Flexibility Timeline



May 11, 2023
The Public Health Emergency (PHE) for COVID-19 declared under section 319 of the Public Health Services Act, expired at the end of the day, May 11, 2023.

May 11, 2023
Most blanket waivers ended in response to emergencies or natural disasters including scope of practice and health and safety waivers. OTC testing coverage ended.

June 30, 2023
SNF enforcement discretion allowing pharmacies to administer vaccines in SNF ended.

December 31, 2023
Medicaid increased FMAP rate will end.

December 31, 2023
Virtual supervision flexibility to expire.

April 30, 2024
End of hospital reporting requirements.

December 31, 2024
End of reporting requirements for nursing homes

December 31, 2024
Extension of Acute Hospital of Care at Home ends.

December 31, 2024
Most Medicare telehealth flexibilities provisions end.

Coverage for COVID-19 Tests

After May 11, 2023

- People with Medicare:
  - Generally, Medicare doesn't cover or pay for over-the counter products. The demonstration that offered free COVID-19 over-the-counter tests ended.
  - Laboratory tests for COVID-19 ordered by your provider will still be covered with no out-of-pocket costs.
  - If you're enrolled in a Medicare Advantage Plan, you may have more access to tests depending on your benefits. Check with your plan.
- Medicaid and CHIP Beneficiaries:
  - COVID-19 over-the-counter tests and laboratory testing are available through September 30, 2024.
  - After that date, coverage and costs for COVID-19 testing may vary by state.
- Private Insurance: mandatory coverage for over-the-counter and laboratory-based COVID-19 PCR and antigen tests ended; coverage will vary depending on the health plan.

Coverage for COVID-19 Vaccines

After May 11, 2023

- People with Original Medicare: continue to have access to COVID-19 vaccinations without out-of-pocket costs.
  - Cost sharing for COVID-19 vaccines may have changed for people with Medicare Advantage (MA) Plans
- Medicaid and CHIP: continued coverage for COVID-19 vaccines and treatments without cost sharing through September 30, 2024
  - Medicaid covers vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including COVID-19, without cost sharing for most people with Medicaid
  - Providers may submit reimbursement claims for administering the COVID-19 vaccine to underinsured individuals through the COVID-19 Coverage Assistance Fund
- Private Insurance: Most forms of private health insurance must continue to cover COVID-19 vaccines given by an in-network provider without cost sharing

Coverage for COVID-19 Treatments

After May 11, 2023

- People with Medicare: Generally, the end of the COVID-19 PHE doesn't change access to treatments like oral antivirals, such as Paxlovid and Lagevrio. Part B covers FDA-authorized COVID-19 monoclonal antibody treatments and products, if all of these apply:
  - You tested positive for COVID-19.
  - You have a mild to moderate case of COVID-19.
  - You're at high risk of progressing to a severe case of COVID-19 and/or at high risk of requiring hospitalization
- Medicaid and CHIP Beneficiaries: After September 30, 2024, coverage and cost sharing for treatments may vary by state
- Private Insurance: The transition forward from the PHE won't change how treatments are covered, and in cases where cost sharing and deductibles apply now, they will continue to apply.

Acute Hospital Care At Home

- Acute Hospital Care at Home expanded CMS' Hospital Without Walls initiative as part of a comprehensive effort to increase hospital capacity, maximize resources, and combat COVID-19 to keep people safe
- The Consolidated Appropriations Act, 2023 extended program through December 31, 2024
- Hospitals can still apply to participate at Qualitynet.cms.gov/acute-hospital-care-at-home

Temporary Medicare Telehealth Changes

Through December 31, 2024 (Consolidated Appropriations Act, 2023)

- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) can serve as a distant site provider for non-behavioral/mental telehealth services
- Generally, any provider who can bill Medicare can bill for telehealth through December 31, 2024
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services
- Some non-behavioral/mental telehealth services can be delivered using phones (audio only)
- You don't need an in-person visit within 6 months of the first behavioral/mental telehealth service, and yearly thereafter
- Telehealth services can be given by a variety of providers (physical therapist, occupational therapist, speech language pathologist, or audiologist)

Permanent Medicare Telehealth Policy Changes

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as a distant site provider for behavioral/mental telehealth services
- Medicare patients can get telehealth services for behavioral/mental health care in their home
- There are no geographic restrictions for originating site for behavioral/mental telehealth services
- Behavioral/mental telehealth services can be delivered using phones (audio only)
- Rural hospital emergency departments can be an originating site

Summary: Telehealth policy changes after the COVID-19 Public Health Emergency

Telehealth Services after the end of the PHE (May 12, 2023)

- CMS significantly expanded the list of services that can be provided by telehealth. Some of these services will continue to be covered under Medicare through December 31, 2024. For details, see this list of Medicare-covered telehealth services.
- All telehealth services need to follow HIPAA rules. Covered health care providers have a 90-day transition period to comply in good faith with the HIPAA Rules without penalties until August 9, 2023.

CMS recently published policy updates for Medicare telehealth services

- CMS clarified that temporary telehealth services added during the COVID-19 Public Health Emergency (PHE) will continue through the end of Calendar Year (CY) 2023.
- Telehealth services provided in the office setting will continue to be paid at the non-facility rate (higher payment) through the end of CY 2023.

Telehealth: Medicaid & CHIP

- For Medicaid and CHIP, telehealth flexibilities aren't tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic
- Coverage will ultimately vary by state
- To assist states with the continuation, adoption, or expansion of telehealth coverage, CMS has released the State Medicaid & CHIP Telehealth Toolkit and a supplement that identifies for states the policy topics that should be addressed to facilitate widespread adoption of telehealth:

  Medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf

Helpful Resources

- **Link to AI/AN Trust Income and MAGI Fact Sheet:** https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIAN-Trust-Income-and-MAGI.pdf

- **Cost Sharing Protections Brochure:** https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Understanding-Cost-Sharing-brochure.pdf

Helpful Resources

- **Medicaid Application (see Appendix B):** https://marketplace.cms.gov/applications-and-forms/marketplace-application-for-family.pdf

Helpful Websites

01	**Medicare**	Medicare.gov
02	**Medicaid**	Medicaid.gov
03	**Social Security**	ssa.gov
04	Health Insurance Marketplace®	HealthCare.gov
05	**Children's Health Insurance Program**	InsureKidsNow.gov
06	**CMS National Training Program**	CMSnationaltrainingprogram.cms.gov
07	**State Health Insurance Program (SHIP)**	shiphelp.org

Helpful Contacts

For questions about Medicaid or CHIP – Contact your state Medicaid or CHIP office directly

- Find the contact information for your state Medicaid office at Medicaid.gov/renewals

For questions about the Health Insurance Marketplace® – Visit HealthCare.gov or contact a local enrollment assister in your area

- Find a list of enrollment assisters in your area at LocalHelp.HealthCare.gov
- Call 1-800-318-2596. TTY users: 1-855-889-4325.

For questions about Medicare – Visit Medicare.gov

- Call 1-800-MEDICARE (1-800-633-4227). TTY users: 1-877-486-2048.
- To get help with the Medicare enrollment form, contact local Social Security office. Find an office near you at ssa.gov/locator or call Social Security at 1-800-772-1213. TTY users: 1-800-325-0778.
- Contact your local State Health Insurance Assistance Program (SHIP) at Shiphelp.org