CMS Strategic Plan

Health Equity

The Centers for Medicare & Medicaid Services (CMS) infuses health equity in everything it does. CMS is working to advance health equity so that each person has a fair and just opportunity to attain their highest level of health regardless of their age, race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

CMS programs cover more than 160 million people across the country through Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. In all, CMS provides health coverage to nearly 1 in 2 Americans. CMS programs are critical to helping to ensure that individuals and families have access to quality health care. CMS goal is to ensure that every person can access the care they seek at an affordable cost.

Health equity is foundational to the CMS Strategic Plan and addressed within each of its pillars. The CMS health equity strategy builds on the Biden-Harris Administration's commitment to advancing racial equity and support for underserved communities through the federal government, as described in President Biden's Executive Orders 13985 and 14091.

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all people. The agency does this by considering the perspectives and lived experiences of individuals and health care professionals, and by integrating safety net providers and community-based organizations into CMS programs. By understanding and removing barriers to health care, CMS aims to eliminate avoidable differences in health outcomes and provide the care and support people need to thrive.

CMS health equity goals:

- ✔ **Close the gaps in health care access, quality, and outcomes** for all patients, including but not limited to those who are members of underserved populations.
- ✔ **Promote culturally and linguistically appropriate** services to ensure health care services and supports are understandable, respectful, and responsive to preferred languages, health literacy, and other diverse communication needs.
- ✔ **Build on outreach efforts** to enroll eligible people across CMS programs.
- ✔ **Expand and standardize the collection and analysis of data**, including data on race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, geography, health-related social needs, and other factors.
- ✔ **Evaluate policies to determine how CMS can support safety net providers** and partner with providers in underserved communities to ensure every person and family can access the care they need.
- ✔ **Engage with – and be accountable to – the communities CMS serves** with two-way communication on policy development and program implementation.
- ✔ **Incorporate screening and support to address health-related social needs** through quality measurement, coordination with community-based organizations, opportunities for payment, and collection of social needs data in standardized formats across CMS programs.

- ✔ **Catalyze health equity actions through CMS programs**, modeling innovative, flexible, and aligned approaches to eliminating disparities in partnership with states, providers, plans, and other stakeholders.
- ✔ **Promote the highest quality outcomes and safest care for all people** by applying the person-centric approach in the CMS National Quality Strategy.

Building Health Equity Into The DNA of CMS

CMS is building health equity into its core work with the goal of taking concrete and specific actions to improve the health care experience and outcomes of the communities we serve. To sustainably drive the health system forward, CMS health equity actions align with six strategic pillars:

Pillar: Advance Health Equity

- ✔ **Rewarding Excellence for Underserved Populations (REUP)**. CMS will reward health care entities who deliver quality care to higher percentages of underserved populations with upside-only monetary awards. New policies and payment enhancements in Medicare and Medicare Advantage like the Star Ratings Health Equity Index and enhancements to the requirements plans must meet to demonstrate network adequacy incentivize excellent care without lowering standards and avoiding unintended penalties on providers treating underserved populations. In 2023, CMS introduced the REUP approach to the Hospital and Skilled Nursing Facility Value-Based Purchasing Programs. This gives providers an opportunity to earn bonus points if they deliver high-quality care and serve a high proportion of underserved populations.

  Impact: Supports high-quality care for underserved populations and enhances equitable payment opportunities for providers disproportionately serving underserved communities. As of 2023, 88% of CMS quality programs had an equity component, including but not limited to the REUP approach, with a goal of reaching 100% by 2025.

- ✔ **"Birthing-Friendly" designation and maternity care quality reporting**. CMS collected data on several quality measures for maternity care including Low-Risk Cesarean Birth Rate, Severe Obstetric Complications, and a Maternal Morbidity structural measure. The Maternal Morbidity structural measure is the basis of the newly launched "Birthing-Friendly" designation on CMS Care Compare site, which is a public designation that indicates whether the hospital or health system has participated in a statewide or national perinatal quality collaborative and implemented the recommended quality interventions in hospital settings to improve maternal health.

  Impact: The collection and public posting of data and the launch of the designation increase transparency and reward hospitals and health systems' commitment to quality improvement. In addition, health plans covering more than 150 million Americans have committed to using the designation in their provider directories.

- ✔ **Sickle Cell Disease Action Plan**. CMS has completed a plan for how to address barriers and challenges faced by patients with Sickle Cell Disease who are also enrolled in CMS programs. This plan 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.

  Impact: This plan can help reduce barriers and challenges for people with Sickle Cell Disease, which disproportionately impacts people of color, including Black and Hispanic communities. CMS programs are taking actions outlined in this plan to improve equitable access, outcomes, and quality of care for people living with Sickle Cell Disease and their families.

- ✔ **Improving workforce training in underserved areas through Graduate Medical Education (GME) allocation**. CMS is allocating 1,200 GME slots, phased in over multiple years, to enhance the health care workforce and fund additional positions in hospitals serving underserved communities. CMS has prioritized training slots in areas that demonstrate the greatest need for additional providers, as measured by Health Professional Shortage Areas.

  Impact: Clinicians who train in residency programs in underserved areas are **more likely to continue their practice nearby** after graduation.

- ✔ **Advancing health equity and caregiver support**. CMS finalized payment to practitioners for training caregivers to support patients with certain diseases or illnesses (e.g. dementia) as part of a treatment plan.

  Impact: Supports care for Medicare enrollees by better training caregivers. Members of underserved communities, including people with disabilities, are **more likely** to have family caregivers.

- ✔ **Addressing health-related social needs**. CMS finalized coding and payment for a Social Determinants of Health (SDOH) Risk Assessment, Community Health Integration, and Principal Illness Navigation services to help patients with health-related social needs and those diagnosed with a serious medical condition to access resources they need to carry out their treatment plan. These policy changes better account for resources involved in furnishing patient-centered care with a multidisciplinary team of clinical staff and other auxiliary personnel, such as community health workers, care navigators, and peer support specialists.

  Impact: These types of services are expected to be disproportionately used to help individuals in underserved communities. For example, the new coding and payment for social determinants of health (SDOH) risk assessment recognizes when practitioners spend time and resources assessing SDOH that may impact their ability to treat the patient.

- ✔ **Hospital reporting for Social Drivers of Health (SDOH)**. CMS finalized the inclusion of the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures in a number of CMS quality reporting programs. These measures require hospitals to report the aggregate rate of patients 18 and older who are screened for five health-related social needs: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. CMS also finalized a change to the severity designation of the three diagnosis codes describing homelessness, to reflect the higher average resource costs of inpatient hospital cases where the patient is experiencing homelessness, compared to similar cases where the patient is not experiencing homelessness.

  Impact: By screening for and identifying such unmet needs, providers will be in a better position to serve patients holistically if they address and monitor what are often contributors to poor physical and mental health outcomes. Facilities and clinicians are increasingly discussing with their patients the underlying social factors which may impact care. We have heard from stakeholders that these conversations – and efforts to address needs – have significantly increased, and from patients who appreciate this attention to their social needs. These actions are consistent with the Administration's goal of advancing health equity for all, including members of historically underserved and under-resourced communities.

- ✔ **Collecting health equity data**. Starting in the fall of 2023, the Marketplace application now asks optional demographic questions regarding sex assigned at birth, sexual orientation, and gender identity.

  CMS also released a resource of health equity-related data definitions, standards, and stratification practices that can be used by various providers, states, community organizations, and others that wish to harmonize with CMS when collecting, stratifying, and/or analyzing health equity-related data.

Impact: Collecting sexual orientation and gender identity data will help improve the Marketplace consumer experience by enabling consumers to attest in a way that better reflects and affirms their identities. These questions will also be used to analyze health disparities in access to coverage. Collecting standardized health equity-related data allows for comprehensive analyses than can be combined or compared across multiple programs and initiatives.

✔ **Mapping Medicare Disparities Tool**. CMS has designed an interactive map, the Mapping Medicare Disparities (MMD) Tool, to identify areas of disparities between subgroups of Medicare enrollees in health outcomes, utilization, and spending. It is an excellent starting point to understand and investigate geographic, racial, and ethnic differences in health outcomes.

Impact: This information may be used to inform policy decisions and to identify underserved populations and geographies.

Pillar: Expanding Coverage

✔ **Increased prescription drug affordability for people with Medicare**, especially those with chronic conditions or low incomes. Through the implementation of the Inflation Reduction Act of 2022, starting in 2023 people with Part D drug coverage **pay nothing out-of-pocket for vaccines** recommended by the Advisory Committee on Immunization Practices (ACIP). Additionally, starting in October 2023, most adults with Medicaid or CHIP **pay nothing out-of-pocket for approved vaccines** recommended by the ACIP. Also in 2023, insulin costs were capped at $35 for a month's supply of each covered insulin product for people with Medicare. In addition, CMS announced the **first 10 drugs covered under Medicare Part D selected for negotiation**. In 2024, Part D included a cap on out-of-pocket costs for the first time and offered expanded eligibility for full benefits under the Low-Income Subsidy program (LIS or "Extra Help").

Impact: As a result of these policies, people with Medicare now have improved access to innovative life-saving treatments at lower costs. Additionally, individuals with Medicare Part D, and most adults with Medicaid or CHIP, now have access to certain recommended vaccines at no out-of-pocket cost to them. As of early 2024, nearly 300,000 low-income people with Medicare currently enrolled in "Extra Help" are benefiting from expanded benefits like no deductibles, no premiums, and fixed or lower copayments for their medications. In addition, people with Medicare have reduced cost-sharing for insulin – no more than $35 for a month's supply per covered insulin product – whereas prior to the cap on insulin costs, people with Medicare **paid about $63** per insulin fill.

✔ **Streamlining enrollment in Medicare Savings Programs**. CMS reduced red tape and simplified Medicare Savings Program enrollment. **Medicare Savings Programs** offer financial assistance to people with limited income and resources to afford their Medicare costs, helping millions of seniors and people with disabilities. CMS also worked to improve access to the Medicare Savings Program through public outreach and partnership with states.

Impact: Improves access to care and economic security for low-income older adults and people with disabilities.

✔ **Enhancing Medicaid and CHIP access**. CMS finalized three historic rules to strengthen access, quality, and enrollment for Medicaid and CHIP enrollees in fee-for-service and managed care service delivery systems. Improvements include national standards for appointment wait times for Medicaid and CHIP managed care plan enrollees and stronger monitoring and reporting related to payment adequacy, among other provisions.

Impact: The policy changes in these rules update policies across Medicaid and CHIP, helping to improve access and ensure coverage for people with Medicaid and CHIP is consistent and comprehensive across delivery systems.

- ✔ **Increasing access to health coverage for DACA recipients**. As part of the Biden-Harris Administration's ongoing commitment to ensuring affordable, quality health care for all, **CMS finalized a rule** that will expand access to health care for Deferred Action for Childhood Arrivals (DACA) recipients. This ensures DACA recipients will no longer be excluded from eligibility to enroll in a Qualified Health Plan (QHP) through the Health Insurance Marketplace, or for coverage through a Basic Health Program (BHP).

  Impact: CMS estimates that this rule could lead to 100,000 previously uninsured DACA recipients enrolling in health coverage through Marketplaces or a BHP.

- ✔ **Improving coverage for dental services**. In the 2023 and 2024 Physician Fee Schedule (PFS) final rules, CMS codified that Medicare payment under Parts A and B could be made for dental services when they are inextricably linked to covered medical treatment. CMS identified in regulations some examples of clinical scenarios under which Medicare could pay for certain dental services. CMS also established a process to review public recommendations for Medicare payments for dental services that are inextricably linked to certain covered medical services.

  The **HHS Notice of Benefit and Payment Parameters for 2025** final rule also provides states the ability to increase coverage of routine adult dental services in most individual and small group market plans.

  Impact: Increasing access to dental coverage and services improves individuals' health and wellbeing, and **reduces disparities in oral health and overall health**. In addition, CMS is supporting the Biden-Harris Administration's Cancer Moonshot initiative by finalizing that Medicare payment can be made for certain dental services linked to several different cancer treatments, including, but not limited to, chemotherapy.

- ✔ **Enhancing Behavioral Health Coverage and Services in Medicare**. In Medicare, several regulatory changes to improve access to behavioral health were finalized to begin in 2024 including a new benefit category for Marriage and Family Therapists and Mental Health Counselors, and for intensive outpatient services. CMS also finalized new coding for principal illness navigation and community health integration that can help a person navigate unmet social needs that can negatively impact a person's mental or physical health if not addressed. CMS also changed the required level of supervision for behavioral health services performed at federally qualified health centers and rural health clinics to promote access to behavioral health for underserved communities. In Medicare Advantage (MA), for 2025 CMS recently finalized network adequacy requirements for outpatient behavioral health to help ensure that people with a MA plan have access to behavioral health providers.

  Impact: Increases access to mental health services, including expanding payment opportunities for health care professionals providing mental health services to individuals in underserved communities. Additionally, increases opportunities to address unmet social needs that may negatively impact an individual's mental or physical health if not addressed.

- ✔ **Power seat wheelchair coverage**. In 2023, CMS revised the National Coverage Determination for power seat wheelchair equipment. With this change, CMS now allows for coverage of power seat elevation equipment for people who use certain power wheelchairs so they can perform transfers.

  Impact: Seat elevation on power wheelchairs can offer health benefits to people with mobility limitations. For example, seat elevation can help someone in a wheelchair more easily move to a bed or bathroom facility, while avoiding injury and reducing the risk of falls.

- ✔ **Improving experiences for dually eligible enrollees in managed care**. A growing number of people dually eligible for Medicare and Medicaid are in managed care, but in many cases enroll in a Medicare Advantage plan that differs from their Medicaid plan. This arrangement often complicates access to services and information. Recent rulemaking will increase the percentage of dually eligible enrollees who are in plans that also cover Medicaid, expand access to integrated materials, unify the appeal processes across Medicare and Medicaid, and continue Medicare services during an appeal for those individuals.

  Impact: For many people, the new rules will result in simpler materials, easier appeals processes, and less "choice overload." Other provisions in the rule will reduce cost-shifting to Medicaid, increase payments to safety net providers that furnish care on an out of network basis to dually eligible individuals enrolled in certain types of Medicare Advantage plans, and expand dually eligible enrollees' access to providers.

- ✔ **Medicaid and CHIP Postpartum Coverage Expansion**. CMS continues to improve access to continuous coverage and quality of care in the postpartum period by working closely with states to encourage uptake of new authority for 12 months of extended postpartum coverage for pregnant people enrolled in Medicaid and CHIP.

  Impact: Increases access to services in the postpartum period for underserved enrollees known to be at higher risk of adverse outcomes.

- ✔ **Expanding access to school-based services**. CMS released a guide to help schools receive payment for delivering care, including behavioral health services, to children in Medicaid and CHIP. The guide provided states with claims guidance, technical assistance, and best practices.

  Impact: Helps address the growing concerns in youth behavioral health, which disproportionately impact children and teens living in low-income communities, ethnic minority youth, LGBTQI+ youth, and those with special needs.

- ✔ **Addressing health-related social needs among people with Medicaid and CHIP**. CMS has approved **groundbreaking section 1115 demonstrations** and **issued guidance on how states can leverage "in lieu of services" (ILOS) flexibilities** for innovative options to reduce health disparities and address unmet health-related social needs. In addition, CMS is supporting **partnerships** and **flexibilities** to help states develop or expand innovative housing-related supports for Medicaid enrollees with disabilities and older adults and has issued guidance on resources to address **transportation barriers**.

  Impact: Unmet health-related social needs like nutrition insecurity, housing instability, and transportation barriers can often have an equal or greater impact on health outcomes than health care. Because individuals who qualify for Medicaid and CHIP are generally low-income, these needs are disproportionately represented among the Medicaid and CHIP populations. Helping states think beyond the clinical drivers of health and providing states the flexibility to address these social drivers of health are essential to improving health equity in Medicaid and CHIP.

- ✔ **Increase Marketplace coverage and enrollment outreach to underserved populations**. Enrollment in the Marketplace has continued to increase each year, with notable growth in Black and Latino communities. CMS continues to focus on enrollment in underserved communities, investing almost $100 million in grant funding to Navigator organizations for the 2024 Open Enrollment Period to provide increased and enhanced enrollment assistance to help consumers find the right health coverage option, complete their Marketplace application, and enroll in coverage in Federally-facilitated Marketplaces.

  Impact: Reduces the uninsured rate among underserved communities. Tailored outreach to underserved populations by local trusted community partners can help overcome barriers to enrollment and ensure eligible individuals and

families understand their coverage options and can pick a health plan that is right for them.

Pillar: Engage Partners

✔ **CMS Health Equity Conference**. CMS hosted its inaugural Health Equity Conference in June 2023 at Howard University and again in 2024 at the Hyatt Regency in Bethesda, Maryland and virtually. The conference convened leaders in health equity from federal agencies, health care organizations, academia, community-based organizations, and others, both in person and virtually.

Impact: Over 5,500 in-person and virtual participants each year to hear about the importance of acknowledging historical and persistent injustices, addressing social drivers of health, and partnering with diverse communities and organizations to address health disparities.

✔ **CMS National Stakeholder Calls**. CMS quarterly National Stakeholder Calls provide an opportunity for CMS to share information related to policies or initiatives with the stakeholder community at large. All stakeholders who interact with CMS programs, policies, or initiatives or work with health care professionals, enrollees, or consumers who rely on CMS services can join these calls.

Impact: Allows CMS partners and members of the public to hear about CMS initiatives.

✔ **Supporting research to improve health access, quality, and outcomes for underserved communities**. CMS awarded a new cohort of grants to minority-serving institutions through the **Minority Research Grant Program (MRGP)**. Awards went to 3 new MRGP grantees in 2023, totaling over $1 million to support research in underserved communities. CMS also awarded three **Health Equity Data Access Program (HEDAP)** grants to enable researchers to access "seats" in the CMS **Virtual Data Research Center (VRDC)** to conduct health services research projects focused on underserved communities. CMS also funded a one-year pilot program focused on increasing access to data for tribal communities, called the Tribal Data Learning Community, which enables Tribal Epidemiology Centers to access CMS claims data sets to enhance health equity in Indian Country.

Impact: These grants support researchers across the country using CMS data to understand and help eliminate barriers to access, quality, and outcomes among Tribal and other underserved communities.

✔ **Resources to help people understand their health coverage**. CMS continuously adds resources to the **Coverage to Care** health coverage literacy initiative to help consumers and partners understand their health coverage and connect to health care services. The newest resource from Coverage to Care includes **Returning to the Community: Health Care After Incarceration** which will assist individuals upon release and re-entering the community to better understand their health care needs, including physical and behavioral health, and to learn key information, terms, people, and titles.

Impact: Health care is an overlooked part of returning to the community. This resource will help connect people to health care services pre- and post-release, learn about insurance coverage types and how to apply, and tips to get started using health coverage to receive needed services to support a successful re-entry and healthy life.

✔ **Providing technical assistance** through the **CMS Health Equity Technical Assistance Program** to support health care professionals, health plans and systems, State Medicaid Agencies, federal, state, Tribal and territorial, and local health agencies, universities, community partners, and all other stakeholders working together to advance health equity through CMS programs.

Impact: CMS health equity technical assistance builds capacity among health care professionals to identify and eliminate barriers experienced by members of underserved communities. It provides quality improvement tools to organizations, providers, and plans who serve underserved communities and helps CMS

partners work together to ensure that all CMS benefits, services, supports, and coverage are available to every individual who is eligible for CMS programs.

- ✔ **Providing materials for states** seeking to implement oral health quality improvement efforts. Tooth decay is a **common and preventable chronic disease among U.S. children**. For children aged 2 to 5 years, about 33% of Mexican American and 28% of non-Hispanic Black children have had cavities in their primary teeth, compared with 18% of non-Hispanic White children. CMS oral health technical assistance to states includes two elements: quality improvement resources to help state Medicaid and CHIP staff and their partners get started, and supplementary materials including approaches and examples of promising and successful quality improvement practices.

  Impact: The Advancing Oral Health Prevention in Primary Care learning collaborative facilitates higher quality oral health care for underserved enrollees known to be at higher risk of adverse outcomes. CMS supported fourteen states in the Advancing Oral Health Prevention in Primary Care learning collaborative, helping states improve oral health among children enrolled in Medicaid and CHIP and connecting them to ongoing dental care.

- ✔ **Translating CMS resources and raising awareness**. CMS translates the "Medicare & You" handbook and other educational materials for Medicare enrollees into languages other than English, and provides educational materials in accessible formats. For example, CMS translates the "Medicare & You" handbook into Chinese, Korean, and Vietnamese. CMS also translates billboards, bus ads, and radio spots into ten languages beyond English and Spanish to share information about CMS programs, coverage, and benefits in enrollees' preferred languages. Consumers and their families can reach out to get more information about their coverage by calling1-800-MEDICARE or their health plan for accessible help in their preferred language.

  Impact: Providing enrollees access to educational resources in their preferred language helps ensure individuals and families understand their benefits and options for coverage.

- ✔ **Medicare Savings Program Public Outreach and Education**. Continued support and outreach for Medicare enrollees on Medicare Savings Programs and other cost-savings programs. During the Open Enrollment period, we included messages on MSP in the outreach campaign. 1-800-MEDICARE representatives are also trained to provide education on the Medicare Savings Programs, as well as other ways for enrollees to reduce their costs.

  Impact: Helps people with Medicare know about programs to reduce their costs and make coverage more affordable for themselves and their families.

- ✔ **Maternal health outreach**. CMS supports HHS' 24-city **Maternal Outcomes Matter Showers (M.O.M.S.)** tour, which is focused on reducing high maternal mortality and morbidity rates in the U.S., especially among Black and American Indian/Alaska Native moms. CMS regional office teams provide information on the importance of selecting a birthing-friendly hospital and educate local OB-GYN clinicians on how to effectively advocate during the birth experience. CMS regional teams also promote extended postpartum care and the importance of pregnancy and birthing support services to improve health outcomes for both new parents and baby.

  Impact: CMS educated over 250 new and expectant mothers and birthing people at every stop of the tour so far, all in communities with high maternal mortality and morbidity rates.

- ✔ **Public website improvements** for improved consumer experience. **CMS.gov**, the online public face of the Agency and the authoritative source of information for Medicare, Medicaid, and Marketplace programs, was redesigned to help people more easily access critical information about their coverage and resources.

Impact: CMS redesigned the "Get Started with Medicare" section of **Medicare.gov**, resulting in an 8%-15% increase in ease of use and overall experience. The 'New to Medicare Campaign,' which included a media mix of search engine marketing, digital display, digital video, and social media, delivered ~900 million web impressions and 10.6 million clicks to the "Get Started with Medicare" section.

✔ **Outreach and engagement with local partners in underserved communities**. CMS conducted 2,500 local outreach events to spread Medicaid and CHIP renewal messaging; over 600 Medicare open enrollment campaign events; and over 350 Marketplace open enrollment campaign events. In addition, CMS conducted over one thousand engagements with rural stakeholders, including 125 listening sessions and in-person visits in 42 states and territories to meet providers and patients where they live and work.

Impact: Fact sheets and consumer-facing information were delivered through in-person events, town halls, and virtual gatherings to help members of underserved communities and the providers who support these communities navigate policy changes and leverage new flexibilities and protections implemented in 2023. Intentional engagement with rural communities offers partners in geographically isolated communities a chance to share their feedback and perspectives with CMS and ensures that CMS can understand and adapt policies to address rural issues and challenges.

Pillar: Innovation

✔ **Advancing health equity through the CMS Innovation Center**. The CMS Innovation Center launched a new health equity initiative in 2022 focused on developing models to promote and incentivize equitable care; increasing participation of safety net providers in models; increasing collection and analysis of equity data; and monitoring and evaluating models for health equity impact. The CMS Innovation Center's **Key Concepts on Health Equity** describes CMS overall approach to incorporating equity throughout our innovative model and demonstration design.

Impact: The CMS Innovation Center has made meaningful progress in each of these areas. This includes all new models incorporating equity elements, as well as new models focused on health conditions that disproportionately impact underserved communities. The CMS Innovation Center has also incorporated health equity into its model evaluations.

✔ **Addressing significant persistent disparities among certain groups of CMS beneficiaries**. CMS recognizes that there are persistent disparities among certain groups of beneficiaries for specific health conditions and outcomes. In response, the CMS Innovation Center announced or proposed several condition-specific models aimed in part at reducing significant persistent health disparities related to Sickle Cell Disease, maternal health, behavioral health, and end-stage renal disease resulting in the need for kidney transplant.

Impact: For example, the **Cell & Gene Therapy (CGT)** Access Model aims in part to address barriers to equitable access to cell and gene therapies, starting with cell and gene therapies for Sickle Cell Disease. The **Transforming Maternal Health (TMaH) Model** aims in part to reduce disparities in maternal health care access and treatment by supporting participating state Medicaid agencies in the development of a whole-person approach to pregnancy, childbirth, and postpartum care that addresses physical, mental health, and social needs. The **Innovation in Behavioral Health (IBH) Model** is designed to support community-based behavioral health organizations and providers to deliver person-centered, integrated care. IBH practices will screen beneficiaries for health-related social needs and develop a health equity plan to address disparities in behavioral and physical health outcomes. The **Increasing Organ Transplant Access (IOTA) Model** is a proposed mandatory model that is part of the **Department of Health and Human Services Organ Transplantation Affinity Group's**

efforts to ensure equitable access to organ transplants, improve accountability for the U.S. organ transplantation system, and increase the availability and use of donated organs.

✔ **Building on CMS accountable care vision to improve care for Medicare beneficiaries. The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model** implements health equity benchmark adjustments to account for social risk among underserved populations and increased Accountable Care Organization (ACO) participation among safety net providers. ACO REACH also requires ACOs to develop Health Equity Plans, report Health Equity Data, and include beneficiary advocates on the ACO's governing boards who must hold voting rights. The recently announced **ACO Primary Care Flex Model** aims to grow participation in ACOs and the Medicare Shared Savings Program, particularly among providers serving underserved populations.

The Shared Savings Program also implemented a new payment option for eligible new ACOs entering agreement periods on or after January 1, 2024 to receive advance shared savings payments referred to as "advance investment payments" so that they have access to upfront capital to make necessary investments to succeed in accountable care. You can learn more by visiting the **Shared Savings Program Application Toolkit** and reviewing the materials under the Advance Investment Payments (AIP) header. Nineteen ACOs are receiving more than $20 million for caring for underserved populations to invest in hiring community health workers, utilizing health assessment and screening tools, and implementing quality improvement activities, such as case management systems, patient registries, and electronic quality reporting. In addition, the Shared Savings Program established a health equity adjustment to an ACO's quality performance score to recognize high quality performance by ACOs serving a higher proportion of underserved populations, and to provide greater recognition of the role of nurse practitioners, physician assistants and clinical nurse specialists in the delivery of primary care.

Impact: ACOs are an important mechanism to reach more underserved populations and close disparities in access to care and outcomes.

✔ **Strengthening primary care financing and sustainability through innovation**. CMS announced the **Making Care Primary (MCP) model**, which aims to improve care, outcomes, and the experience for people with Medicaid and Medicare in 8 states by supporting the delivery of advanced primary care services including care management and care coordination, and equipping primary care providers with tools to form partnerships with specialists and community organizations to address health-related social needs. In addition, the **States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model** is a multi-state total cost of care model that aims to increase investment in primary care, improve care coordination, provide financial stability for hospitals, and increase screening for patients with Medicare and Medicaid related to community resources and social drivers of health.

Impact: A strengthened primary care infrastructure may lead to better access to high-quality primary care services. Having more access points for primary care helps individuals, including those in underserved communities, access primary and preventive care when and where they need it, in affordable and appropriate settings, and improves health outcomes.

✔ **Addressing health-related social needs via community resources: lessons from Accountable Health Communities**. The **Accountable Health Communities (AHC) Model** which began in 2017 and ended in 2022, tested the impact of identifying and addressing Medicare and Medicaid enrollees' health-related social needs (HRSNs) through screening, referral, and community navigation services on health care use and costs. This report shares lessons learned from the model.

Impact: Other Innovation Center models are required to collect and report demographic and, where feasible, HRSN data to CMS. Eleven models require that beneficiaries are screened for HRSNs and referred to resources that address any unmet needs.

Pillar: Protect Programs

✔ **Ensuring safe and high-quality care for nursing home residents**. To promote safe and high-quality care for individuals in nursing homes, CMS issued the **Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting** rule to establish comprehensive minimum staffing requirements for nursing homes. Additionally, the rule requires states to collect and report on the percentage of Medicaid payments to nursing facilities and intermediate care facilities for individuals with intellectual disabilities that are spent on compensation for direct care workers and support staff.

Impact: National minimum nurse staffing standards help ensure access to safe, high-quality care for over 1.2 million nursing home residents.

✔ **Protecting coverage during Medicaid and CHIP renewals**. Following the end of pandemic-era continuous enrollment policies for Medicaid, states resumed routine renewals. CMS has engaged in comprehensive efforts to help protect coverage during this process. This includes, in part, strategies for states to make it easier to renew Medicaid and CHIP coverage for eligible people, approving nearly 400 strategies in states nationwide; making it easier to transition to Marketplace coverage on HealthCare.gov and providing access to a special enrollment period; outreach and engagement with trusted partners in underserved communities; and holding states accountable to ensure eligible individuals maintain coverage.

Impact: By helping to reduce coverage disruptions, these policies have helped to maintain access to care for eligible individuals.

✔ **Protecting consumers from surprise bills**. CMS continues to implement the No Surprises Act to end surprise medical bills, ensure that providers give uninsured consumers up-front cost estimates to help them plan their care, and remove insured consumers from payment disagreements between their providers, health care facilities, and health plans.

Impact: Consumers are protected from unexpected medical bills and have tools to help them better understand their medical costs, including a **new website on CMS.gov** providing consumer- and advocate-facing information posted in English and Spanish. The website receives over 45,000 visits per month. Uninsured consumers receive good faith estimates from providers in advance of care and have the right to dispute bills that exceed their estimate by $400 or more, aiding populations with historically higher uninsured rates, such as Black and Latino consumers.

✔ **Interoperability and prior authorization policies**. CMS finalized the Interoperability and Prior Authorization final rule and the 2024 Medicare Advantage and Part D final rule to streamline prior authorization and improve data exchange practices. Collectively, these final rules, advance timely access to care and reduce enrollee disruption.

Impact: This improves patient, provider, and payer access to interoperable patient data and streamlines prior authorization processes for certain payers. They also ensure that enrollees have consistent access to medically-necessary care. The streamlined processes reduce provider burden, allow physicians more quality time with their patients, and will result in approximately $16 billion in savings over 10 years.

✔ **Annual health equity analysis of utilization management policies and procedures**. Starting in 2025, CMS is requiring Medicare Advantage organizations to analyze their utilization management policies and procedures from a health equity perspective.

Impact: Utilization management policies and procedures, including prior authorization, may have a disproportionate negative impact on underserved populations and may lead to delay or denial of access to certain services. The new requirements will create additional transparency, reduce disruptions for MA enrollees, and ensure they receive consistent access to medically necessary care.

✔ **Inclusion, Diversity, and Protection of privacy**. CMS published a federal register notice that announces the addition of data elements [where? In what forms, systems, processes, reporting mechanisms?] that account for providers who perform services from their home, and additional gender code options for the National Plan and Provider Enumeration System (NPPES) that is used to assign and maintain National Provider Identifiers.

Impact: By expanding gender code options beyond Male (M) and Female (F), these additional codes align with CMS diversity, equity, and inclusion initiatives. In addition, these changes address privacy and safety concerns for physicians who exclusively provide telehealth services from their own home and whose home addresses are publicly available through the NPPES registry. These changes improve accuracy in publicly available data and support unique identification and enumeration of health care providers.

Pillar: Foster Excellence

✔ **Diversity, Equity, and Inclusion (DEI) Strategic Plan**. To align our goal of promoting equity, CMS is also acting internally to create a more diverse, equitable, and inclusive workplace. In 2022, CMS published its first-ever DEI Strategic Plan. CMS understands and supports the value of diversity in improving organizational efficiency and effectiveness. We continually strive to promote a climate of cultural, professional, and personal diversity in our workforce.

Impact: The plan enhances current DEI initiatives and provides a more comprehensive and strategic focus on DEI to enable CMS to establish a more inclusive and equitable culture.

✔ **Ensuring accessibility across CMS programs**. CMS continues to strengthen resources offered to contractors, developers, and the public to support compliance with Sections 508, 504, and 501 of the Rehabilitation Act to ensure all information and communication technology is accessible to CMS employees and members of the public who experience disabilities. CMS aspires to be a model employer of people with disabilities and seeks to ensure equitable access to CMS programs and services.

Impact: CMS serves and employs people with disabilities. The agency provides resources and program support geared toward Sections 501, 504, and 508 compliance which help CMS ensure all procurements, contracts, and information and technology is accessible to every CMS employee and enrollees with disabilities across CMS programs.

✔ **Training resources to advance health equity**. CMS strives to provide all employees and contractors with an understanding of the agency's goals to advance health equity and eliminate disparities. CMS has several external and internally available resources to train contracting officers, program leads, contractors, and partners on key health equity concepts, interventions to reduce disparities, and barriers and opportunities underserved communities may face in accessing CMS programs.

Impact: CMS training resources support ongoing education among employees across programs. This helps employees across operations, policy, and programs understand actions they can take to support CMS strategic pillar to advance health equity.

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