Centers for Medicare & Medicaid Services
National Stakeholder Call with the CMS Administrator
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Eden Tesfaye: Hello and good afternoon to the over 1,500 folks on this call. My name is Eden Tesfaye, and I have the pleasure of serving as Senior Advisor in the Office of the Administrator here at CMS. Thank you so much for joining us today for our second Centers for Medicare and Medicaid Services National Stakeholder Call of 2024. Can you all believe it's already April? I guess May at this point. I'm going to walk through today's agenda and then turn it over to our phenomenal speakers, our leadership here at CMS. But before I do that, I have a few housekeeping items. This call is being recorded. For those of you who want to view American Sign Language, select the round interpretation icon on your Zoom task bar, then select American Sign Language to view interpreters in a separate window. Also, while members of the press are welcome to attend the call, please note that all press/media questions should be submitted using our Media Inquiries Form, which may be found at cms.gov/newsroom/media-inquiries. We will not be accepting live questions during the call. However, we did solicit some questions beforehand and will answer a handful of those today. Everyone should see today's agenda on their screen. We have a full agenda that includes CMS Administrator Chiquita Brooks-LaSure and her leadership team, who will provide highlights and insights on CMS' recently announced accomplishments, including a more in-depth look at a variety of policy announcements and how our cross-cutting initiatives are advancing CMS' strategic plan. These presentations will be followed by a Question and Answer session, and those questions, as I noted recently, were selected from some pre-sourced questions from all of you who are joining us today. And so, with that, I'll turn it over to our fearless leader, Chiquita Brooks-LaSure. Administrator, turning it over to you.

Chiquita Brooks-LaSure: Thanks so much, Eden, and let me also join you all by saying hello and thank you for joining our quarterly call today. It's always remarkable just how busy we are here at CMS, and the last few months are no exception. We are excited to share some of the activities and provide some updates to all of you today. As you may know, today marks the last day of National Minority Health Month. It is an important reminder that we continue to have disparities in our health care system and that people's unique cultures, environments, and circumstances contribute to their overall health. At CMS, we are striving to make sure that as we implement policy and operations, we are being intentional about addressing disparities and working to achieve health equity, and that is our goal throughout the year. Person-centered care is fundamental to our mission to bridge disparities and transform our healthcare system into one that delivers equitable outcomes for all people, no matter what they look like, where they are from, or how much money they make. You'll hear more about this work and how we're using our levers to meaningfully impact the people that our programs serve.

Our agenda today includes an in-depth discussion about several recent policies. You'll hear first from Dr. Meena Seshamani, who will now share the work we're doing to make prescription drugs more affordable this year, as well as guardrails and protections for Medicare Advantage (MA) marketing that we recently finalized in the Medicare Part C and D final rule. I've already been hearing from seniors across the country who have hit their catastrophic cap, which I think is one of the remarkable changes that we are already starting to see as part of the new prescription drug law.

Following Dr. Seshamani, Sara Vitolo will share an overview of how our recent final rules strengthen access to Medicaid and CHIP (Children's Health Insurance Program), helping millions of people with modest incomes and underserved communities get the care they deserve. With input from all of you, we are working hard to make it easier for people to not only enroll in Medicaid but also for Medicaid beneficiaries, and enrollees, to be able to see the doctors and the nurses and get the care that they need.

Then, Dr. Dora Hughes will discuss how our recently proposed inpatient payment rules for 2025 will help advance equity. She will also share some insight into the recently finalized rule requiring certain standards for nursing home staffing, which we all hope will have a meaningfully positive impact on the care of our nation's elders and people of all ages who reside in nursing homes as well as the incredible workforce that cares for them.

Last but certainly not least, Dr. Liz Fowler will share details about our newest CMS Innovation Center models, including the Cell and Gene Therapy Access and Transforming Maternal Health Models. I'm excited how the Innovation Center team continues to tackle some of the most challenging and critical issues that face our healthcare system in an attempt to deliver better care for people. We're changing up our quarterly meetings just a bit so that we'll have more time to answer your questions. Your input makes our program stronger, which is why we look forward to having these discussions with you. And so now I'll turn it over to Dr. Meena Seshamani.

Dr. Meena Seshamani: Thank you so much, Administrator, and it's great to be here with all of you. As the Administrator mentioned, I'm Dr. Meena Seshamani. I'm the Deputy Administrator and Director of the Center for Medicare. And in the first quarter of this year, I'm excited to share with you the work that our center has been doing. We've been very busy delivering on our historic work to drive toward a future where Medicare beneficiaries have access to and receive equitable high-quality and whole-person care that's affordable and sustainable across all Medicare programs. My team is continuing to lead the implementation of the Inflation Reduction Act that lowers drug costs for people with Medicare and the Medicare program. We are actively engaged in negotiations with the manufacturers of all the drugs that were selected for negotiation this year, and we're continuing to learn from this first cycle of negotiations to prepare for the next cycle.

We have also finalized the first part of our guidance on the Medicare Prescription Payment Plan, which we affectionally call M3P, and we put out guidance on the second part for stakeholder feedback. For the seniors who may benefit from this, this program may help them to spread out the cost of their prescription drugs over the year if they choose, starting next year. Our team is continuing to put out educational materials to help beneficiaries and their plans determine who

may best benefit from this program. As you know, keeping Medicare choices stable and affordable is core to our work, and we're also focused on improving all aspects of Medicare, including traditional Medicare, Medicare Advantage, and Medicare Part D prescription drug coverage. Within these markets we are focused on three things: First, protecting beneficiaries, second, improving access to care and treatment, and third, promoting competition. With our most recent Medicare Advantage and Part D final rules, we took bold actions to support these goals, including improving access to behavioral health care by adding a new facility type that includes several behavioral health provider types to MA network adequacy requirements; adding new guardrails to planned compensation for agents and brokers, including standardized plan compensation that addresses add-on payments; preventing personal beneficiary data collected by third-party marketing organizations to market to or enroll someone in an MA or Part D plan, preventing that from being shared with another third party without specific permission; creating policies to increase the utilization and appropriateness of supplemental benefits such as new requirements related for MA plans to send a personalized notification mid-year to alert beneficiaries of unused benefits; streamlining enrollment options for individuals with both Medicare and Medicaid by providing more opportunities for integrated care; putting in place new requirements to conduct an annual health equity analysis of plans prior authorization policies and procedures and to publicly post this analysis to improve transparency on the effects of prior authorization on underserved communities; and creating more flexibility for Part D plans to more quickly substitute lower-cost biosimilar biological products for their reference products.

We also finalized our Medicare Advantage and Part D payment update called the Rate Announcement. We finalized policies that are projected to result in a 3.7% average increase in payment to MA plans year over year. This means the federal government would pay over $16 billion more in 2025 to MA plans than it did in 2024, which ensures that MA plans are paid adequately to provide stability for enrollees. The update of a 3.7% increase for 2025 is slightly larger than the update we finalized last year, which was 3.32%. That increase resulted in stable offerings in 2024 for people with Medicare, including premiums, supplemental benefits, and choice. In that Rate Announcement, we also finalized improvements to the structure of the Medicare Part D drug benefit for calendar year 2025 that will result in lower drug costs for millions of people with Medicare through the concurrent release of the Final Calendar Year 2025 Part D Redesign Program Instructions. Thanks to the Inflation Reduction Act, annual out-of-pocket costs will be capped at $2,000 for people with Medicare Part D in 2025, leading to a richer, more generous Part D benefit and even more savings for people with Medicare. All of these policies together strengthen protections for the millions of people who rely on MA and Medicare Part D prescription drug coverage.

But that's not all. On the traditional Medicare side, we also recently announced the proposed rules for the inpatient long-term care hospitals, inpatient psychiatric hospitals, skilled nursing facilities, inpatient rehab hospitals, and hospices, paid under traditional Medicare and doing so in a way that advances our priorities for health equity and care transformation. So, a couple of highlights here. Under the Inpatient Prospective Payment System, CMS is proposing to enhance payments for care provided to individuals who are experiencing housing insecurity, aligning with broader administration efforts recognizing housing stability's impact on health. We also proposed new technology add-on payments to enhance access to new gene therapy for sickle cell disease and introduced a separate payment for small hospitals for maintaining a buffer stock of essential

medicines to ensure reliable care delivery. Collectively, these proposals improve access to care, particularly in underserved communities. And I also want to call attention to the Inpatient Psychiatric Facilities Proposed Rule. Among other policies, in this rule, we proposed revisions to the methodology for determining payment rates as required by the Consolidated Appropriations Act of 2023. Importantly, these proposals would support the provision of high-quality behavioral health treatment in inpatient psychiatric facilities, consistent with the Biden administration's Unity Agenda, and focus on addressing the mental health crisis in our country.

I know that I have gone through a lot of information with you on the changes that are afoot with the Medicare program, and I want to emphasize that all of this work has only been possible through partnership with all of you. We encourage you to submit comments on all of the proposed rules. The deadlines for submission for each rule can be found on CMS.gov. We also appreciate you getting the word out about the new benefits available for people with Medicare and the new opportunities for clinicians to engage in our programs. So, thank you so much for joining us today, and I'll now turn it over to Sara Vitolo. Sara?

Sara Vitolo: Thank you, Meena. I'm Sara Vitolo. I'm Deputy Director of the Center for Medicaid and CHIP Services. Over the last month, CMS has released several major rules intended to improve access to quality services for people eligible for Medicaid and CHIP. These rules are a major step forward for the program and the people we serve. I'm going to use this time to highlight some of the key provisions in three of those areas. The first of the groundbreaking rules is the Eligibility and Enrollment Final Rule, released in the Federal Register on March 27. This rule made it easier for children and adults across the country to keep their coverage by eliminating the arbitrary waiting periods before a child who is determined eligible is able to receive coverage, eliminating the annual and lifetime limits on children's coverage in CHIP, making it easier to transfer children from Medicaid to CHIP when a family's income rises, ending the practice of locking children out of CHIP coverage when a family is unable to pay premiums, requiring states to provide all individuals with at least 15 days to provide any additional information when applying for the first time and 30 days to return documentation when renewing coverage, and prohibiting states from conducting renewals more frequently than every 12 months, and preventing states from requiring in-person interviews for older adults and those with disabilities**.** These provisions are built on the provisions finalized earlier in the year that improve eligibility and access to certain enrolled in Medicare—in the Medicaid Savings Programs, which are Medicaid programs that pay the Medicare premiums and cost-sharing for people with low income. These eligibilities and enrollment improvements are especially critical, given the backdrop of Unwinding. We are quickly approaching the one-year mark when full Medicaid and CHIP renewals [inaudible].

Eden Tesfaye: Sara?

Sara Vitolo: Yes?

Eden Tesfaye: I don't mean to interrupt you. I'm so sorry, and I'm sorry to our audience. Your audio is a little off, so I'm going to ask that we shift to Dr. Dora Hughes while we take care of your audio on the back end and come back to you. I apologize for the interruption.

Sara Vitolo: No problem. Thank you, Eden.

Eden Tesfaye: Thank you. We'll turn it back to Sara in a jiffy. Dora, we'll turn it over to you, Dr. Hughes, to give your remarks.

Dr. Dora Hughes: Thank you. And apologies, Sara, for stepping into your place here. But good afternoon. I'm Dora Hughes, Acting CMS Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality, or CCSQ. CCSQ is committed to improving performance on key quality and patient safety metrics through the application of CMS levers such as quality measurement, payment, health and safety standards, and quality improvement support. As our first highlight to share, on April 22, as many of you may be aware, CMS issued a final rule to establish the first-ever minimum nurse staffing requirements within nursing homes, hoping to drive the delivery of safe quality care for all residents. This final rule is a cornerstone of President Biden's action plan for nursing home reform. CMS is unwavering in its commitment to improving the safety and quality of care for the over 1.2 million residents receiving care at Medicare- and Medicaid-certified nursing homes. Adequate staffing is critical to ensuring that nursing homes provide an environment where all residents receive safe, high-quality care. Adequate staffing is the measure most closely linked to the quality of care residents receive. However, despite existing requirements that nursing homes provide sufficient levels of staffing, persistent understaffing remains. CMS received over 46,000 public comments on its proposed rule. As a part of the public comment period, we received many personal stories that shared instances of residents waiting and hoping for someone to help them in their time of need. Many residents reported going hours without toileting assistance, days without showers, having medications delayed or missed entirely, and experiencing preventable safety events, such as falls or pressure ulcers. Many family members, within their comments, also recounted their efforts to help stressed and exhausted nursing staff provide basic care and basic support to their loved ones. Unfortunately, these dire conditions disproportionately affect residents of color, with existing literature demonstrating that residents of color do not receive nursing home care of comparable quality to white residents. One study found that nursing homes that serve a high proportion of Black residents have fewer nurses and staff members, have more deficiencies, and are located in poorer counties as compared with nursing homes serving chiefly white residents.

CMS has finalized a total nurse staffing standard of 3.48 hours per resident day, which must include at least 0.55 hours per resident day of direct registered nurse care and 2.45 hours per resident day of direct nurse aide care. While CMS believes these final requirements are balanced and achievable, we acknowledge that some nursing homes may face unique challenges, particularly those in rural communities. As such, this final rule provides a staggered implementation time frame for the minimum nurse staffing standards and 24/7 Registered Nurse requirements—over a five-year period for rural nursing homes and over a three-year period for non-rural facilities. Additionally, time-limited hardship exemptions to both the minimum staffing standards for hours per resident day and the 24/7 Registered Nurse requirement are available for nursing homes facing true workforce challenges. However, these exemptions are meant to provide temporary relief, and we expect that nursing homes that receive an exemption will work toward full compliance as quickly as possible.

As a second highlight for this quarter, CCSQ has several proposals included in the FY2025 Hospital Inpatient Prospective Payment System, or IPPSS, and Long-Term Care Hospital Prospective Payment System Proposed Rule that was released earlier this month on April 10. As part of the recent proposed rule, CMS is proposing the following changes to the Long-Term Care Hospital Quality Reporting Program. First, CMS is proposing to add three new social drivers and determinants of health assessment items—Living Situation, Food, and Utilities—to the Long-Term Care Hospital, or LTCH, Inpatient Rehab Facility, and the Skilled Nursing Facility Quality Reporting Programs. The addition of the social drivers and determinants of health items across these programs not only allows CMS to elevate the voices of the patients and their caregivers but also improves data collection on social drivers and determinants of health items, fully aligned with CMS' National Quality Strategy goals of equity and engagement.

Second, currently, the Long-Term Care Hospital, or LTCH, Quality Reporting Program, does not have a star rating system to supplement existing publicly reported quality information for individuals to use when comparing Long-Term Care Hospital quality of care. CMS intends to develop a five-star methodology for Long-Term Care Hospitals that can meaningfully distinguish the quality of care offered by providers and would also be reported on both Care Compare and the Provider Data Catalog. Our ratings for LTCHs, or Long-Term Care Hospitals, will be designed to help consumers quickly identify differences in quality when selecting a provider, while also, we believe, helping to promote competition in healthcare markets. CMS is seeking public comment on these concepts.

Third, CMS is requesting feedback on potential measurement concepts that could be developed into long-term care Quality Reporting Program measures. CMS continues to evaluate, refine, and develop new Quality Reporting Program measures to ensure that our beneficiaries and caregivers have meaningful information for making informed healthcare decisions. Specifically, CMS is seeking input on the measure concept of pain management, depression, and a composite measure of vaccinations.

Lastly, and fourthly, through the IPPS Long-Term Care Hospital Proposed Rule, CMS is seeking to advance patient safety and outcomes across the hospital Quality Reporting Programs by requesting feedback on ways to build on current measures in several Quality Reporting Programs that account for unplanned patient visits to encourage hospitals to improve their discharge processes. We are specifically interested in input on adopting measures that better represent the range of outcomes of interested patients, including unplanned returns to the emergency department and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.

So, moving to our next topic, I wanted to provide an update on how CMS is using its leverage to advance health equity through our collaboration with another federal agency, our partners at the Health Resources and Services Administration, or HRSA, to improve the performance and equity of the U.S. Organ Transplantation System, also known as the Organ Procurement and Transplantation Network, or OPTN. Both agencies, CMS and HRSA, share responsibility for overseeing organ donation, procurement, and transplantation. In March of 2023, HRSA announced the OPTN Modernization Initiative to better serve the needs of patients and families. Shortly thereafter, in April of 2023, CMS reinforced its strategy for oversight of the Organ

Procurement Organization, or OPO, with the release of the 2023 Organ Procurement Organization Public Performance Report, reflecting the first full year of operations following the publication of the December 2020 Conditions for Coverage Final Rule. This report used the new outcome measures in tier status, reflecting OPO performance data from 2021. CMS expects to release the 2024 OPO Performance Report soon, hoping for late May or early June.

In September of 2023, CMS and HRSA announced the creation of the Organ Transplantation Affinity Group, or OTAG. Efforts by OTAG include further strengthening the accountability to patients, their families, and the public by advancing equitable access to transplantation, collecting data, and establishing criteria for standardization and transparency of wait lists. Access to organ transplantation varies not only by geography but also by factors such as race, ethnicity, disability status, and socioeconomic status. For example, data from the OPTN database show that in 2022, only 32.9% of Black people on the waiting list received organ transplants, while 52.6% of white people on the waiting list received organ transplants. We hope that OTAG's efforts can help reduce the health disparities.

Before I close, I have to tout CMS' 2024 Annual Quality Conference we held earlier this month. We had thousands—over 5,000—of in-person and virtual attendees from across the healthcare industry, all gathered to promote the creation of an inclusive, accessible, and innovative future for healthcare. This year's conference theme is Resilient and Ready Together: Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities. We explored opportunities for positive change in health care, covering important topics such as health equity, collecting and using quality data, engaging partners in communities, behavioral and physical health care, health care system resiliency and readiness, high reliability and quality improvement, new technology innovation, patient safety—the list goes on. It was truly a robust and very inspirational conference. If you weren't able to attend this year, we hope you can join us next year to continue our partnership in advancing quality health care. And with that, I'll turn it back to you, Eden, or not sure if we're turning it back to Sara or transitioning to Dr. Fowler. So, I will turn the mic back to you.

Eden Tesfaye: Thank you, Dr. Hughes, and thanks for those updates. We apologize for the inconvenience. We wanted to make sure you folks could hear everything Sara was sharing with you. So, with that, Sara, turning it back over to you. And thank you so much for accommodating that tech glitch. You're on mute, Sara.

Sara Vitolo: Eden, can you hear me OK? Hello?

Eden Tesfaye: Loud and clear.

Sara Vitolo: Oh, great, wonderful. Please interrupt if it goes out again. I'm sorry, everybody, for the Darth Vader voice that you were subjected to. So, I think if it's OK, I'll start from the top. I wanted to highlight some of the key provisions in three of the rules that we released recently. So, the first of these groundbreaking rules is the Eligibility and Enrollment Final Rule. This was released in the Federal Register on March 27. This rule will make it easier for children and adults across the country to get and keep their coverage by eliminating arbitrary waiting periods before a child who is determined eligible is able to receive their coverage, eliminating annual and

lifetime limits on children's coverage in CHIP, making it easier to transfer children from Medicaid to CHIP when a family's income rises, ending the practice of locking children out of CHIP coverage and renewal if a family is unable to pay premiums, requiring states to provide all individuals with at least 15 days to provide any additional information when applying for the first time, and 30 days to return documentation when renewing coverage. And prohibiting states from conducting renewals more frequently than every 12 months, prohibiting states requiring in-person interviews for older adults and those with disabilities.

These provisions build on the provisions finalized earlier in the year that improve eligibility and access for people enrolled in the Medicare Savings Program, which are actually Medicaid programs that pay the Medicare premiums and cost-sharing for people with low income. These eligibility and enrollment improvements are especially critical given the backdrop of Unwinding. We are quickly approaching the one-year mark when full Medicaid and CHIP renewals started, following the end of the Medicaid Continuous Enrollment Condition. Over the last year, Unwinding has put a huge spotlight on what many of us have known for so long—that renewing Medicaid and CHIP coverage is far from easy and sometimes leads people to fall through the cracks. Our priority has been helping people stay covered, whether in Medicaid, CHIP, Marketplace, or Medicare, and we're grateful to everyone on this call for your efforts during this challenging process. And as we all know, this work does not end with Unwinding. It continues with sustained focus and commitment from CMS and all of us here.

Last week, we released two related rules. The first that I'll talk about is the Ensuring Access to Medicaid Services Final Rule, which we call the Access Rule. This advances access to care and quality of care and will improve health outcomes for Medicaid beneficiaries across fee-for-service and managed care delivery systems, including Home- and Community-Based Services (HCBS) provided through those delivery systems. CMS has actively sought to improve access to care and services for the people enrolled in the Medicaid program but has been limited by outdated regulations that need to be more comprehensive and consistent across all delivery systems and coverage authorities. These improvements seek to increase transparency and accountability, standardize data monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid programs, with the goal of improving holistic access to care. This final rule along with the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule, which is a mouthful, we call it the Managed Care Final Rule, underscores our commitment to strengthening access through coverage and care.

So, for the Managed Care Rule, managed care is the predominant delivery system in Medicaid and CHIP, with over 80% of people enrolled in Medicaid and CHIP receiving some or all of their care through managed care. In recent years, CMS and states have strived to ensure that beneficiaries have access to high-quality care, to ensure adequate provider payment, and to provide comprehensive program monitoring and oversight. This final rule helps build stronger managed care programs to better meet the needs of the people enrolled in Medicaid and CHIP by improving access to and quality of care. The final rule specifically strengthens standards for timely access to care and states' monitoring and enforcement efforts, enhances quality and fiscal and program integrity statements for state-directed payments, specifies the scope of "in lieu of services and settings" to better address health-related social needs, further specifies medical loss ratio requirements, and establishes a quality rating system for Medicaid and CHIP managed care

plans. Together, these three rules strengthen the Medicaid and CHIP programs. They ensure people can get and stay covered and have access to the high-quality care they need. We're looking forward to working closely with all of you on the implementation of these rules. With that, I'll turn things over to Dr. Liz Fowler.

Dr. Elizabeth Fowler: Thanks so much, Sara. Thanks, Dr. Hughes, Eden, and Administrator Brooks-LaSure, and thanks to all of you for taking the time to be with us today. A lot of exciting updates to share from the Innovation Center. At the last CMS Quarterly Stakeholder Meeting in January, we talked about the new opportunities for states to partner with the Innovation Center on key policy areas through our new state-based models, including the Transforming Maternal Health Model, the Innovation and Behavioral Health Model, and the more advanced AHEAD (Advancing All-Payer Health Equity Approaches and Development) Model.

Since our last quarterly call, and as the Administrator highlighted in her opening remarks, we've also announced the Cell and Gene Therapy (CGT) Access Model that will focus on newly approved treatments for sickle cell disease. Under the GCT Access Model, CMS will negotiate an outcomes-based agreement with manufacturers on behalf of states. The agreement will tie manufacturer payments to improved health outcomes for people with Medicaid and will include additional pricing discounts and a standardized access policy. As part of the model, CMS will support the implementation of financial and clinical outcome measures, reconciliation of data, and evaluation results. States decide whether to participate in the outcomes-based agreement voluntarily, and success in the model will be measured by achieving increased equitable access to high-cost, life-saving treatments across the country, savings for states and CMS, and improved quality of life for beneficiaries. Health equity is a priority in CGT, and we are focused on understanding the potential barriers to equitable access to cell and gene therapies that we may need to address in the model. For example, the long distances that patients might have to travel to receive therapies, the lengthy process of cell harvesting and administration of the therapy, and the need for ancillary services such as fertility preservation in the case of sickle cell disease. It’s a model we’re very excited about, and we are currently on track for the model to start in January 2025.

The Innovation Center continues to make progress toward the CMS accountable care goal of having 100% of Medicare beneficiaries and the vast majority of Medicaid beneficiaries in an accountable care relationship with their provider by 2030. The most recent example of that progress is our announcement earlier this month of the ACO (Accountable Care Organization) Primary Care Flex Model, or ACO PC Flex, which provides new opportunities to promote and support primary care within the Medicare Shared Savings Program. The ACO PC Flex Model is an important example of our efforts across the agency, and it’s also an example of using the Shared Savings Program as a chassis for innovation instead of creating a separate stand-alone model. The model provides two new payment mechanisms for participating ACOs—a one-time advanced shared savings payment that can be used to cover costs associated with forming an ACO, if that's relevant, and also to administrative costs for implementing the model's required activities. And second, a monthly prospective primary care payment that’s intended to increase the predictability of primary care funding for low-revenue ACOs. In contrast to previously tested models, the prospective payment rate is not based on historical spending estimates. Instead, it’s based on a county’s average primary care spending before social and clinical risk factors are

applied. This will help reduce entrenched disparities in primary care investments and utilization by giving all beneficiaries access to the same level of care regardless of which ACO serves them in the county. The model includes policies designed to ensure that the funds flow to primary care providers and are used specifically to support primary care.

In addition to advancing models that promote and support primary care, we've also been spending a great deal of time and attention on the role of specialists and specialty care. In February, we began providing additional data, including claims data for services, suppliers, and associated payments on episodes of care to shared savings ACOs and ACO REACH (Realizing Equity, Access, and Community Health) organizations.

Two weeks ago, we announced the Transforming Episode Accountability Model, or TEAM model, a five-year, episode-based payment model for five surgical procedures. The proposed model would test whether hospital financial accountability for these five surgical procedures reduces Medicare spending while preserving or enhancing the quality of care for Medicare beneficiaries. As proposed, TEAM would be a five-year mandatory model for hospitals located within selected geographic areas. While the mandatory nature of the model is a shift from our previous bundle payment models, qualitative interviews with past model participants and other key stakeholders suggest that providers are expecting the Innovation Center to move in this direction after more than a decade of work in this area, and they agree that episode-based payment models align quality improvement goals across providers and support improved care processes and outcomes for beneficiaries. TEAM would support CMS' broader efforts for health equity by offering flexibilities to hospitals that care for a higher proportion of underserved beneficiaries, such as safety net hospitals. Since this model is mandatory, it's proposed through notice and comment rulemaking, and of course, we welcome input during this comment period.

For more detail on our strategy to better integrate specialty care and primary care, we published a blog in Health Affairs earlier this month that outlines the strategy and provides an update on our recent progress. I'm going to stop there. Thank you again for being here and stay tuned for more from the Innovation Center. With that, turning it back over to Eden, who will move us into the Question and Answer portion of today's call.

Eden Tesfaye: Thank you so much, Liz. Really appreciate it. So, our first question is for Deputy Administrator and Center for Medicare Director, Dr. Meena Seshamani. Dr. Seshamani, when will the final guidance regarding education and outreach for the Medicare Prescription Payment Plan be finalized and published?

Dr. Meena Seshamani: Thank you so much for that question. We plan to release the final, Part 2 guidance this summer, and we understand the urgency for the release of all these materials. The team is doing their best to get them out as fast as possible.

Eden Tesfaye: Thank you, Dr. Seshamani. Our next question is for the Deputy Director of the Center for Medicaid and CHIP Services, Sara Vitolo. Sara, what provisions in the Medicaid Managed Care Final Rule will improve enrollees' access to health care services?

Sara Vitolo: Thanks, Eden. The rule finalizes new standards to help states improve their monitoring of access to care in Medicaid and CHIP-managed care by establishing new national standards for maximum appointment wait times for certain services, requiring the use of annual secret shopper surveys to validate compliance with appointment wait time standards and provider directory accuracy, requiring the use of annual enrollee experience surveys for each managed care plan, requiring an analysis of managed care plan payments to providers for specific services as a percentage of Medicare and Medicaid fee-for-service and lastly, establishing the Medicaid and CHIP quality rating systems to empower beneficiaries to choose a plan that best suits their access and coverage needs.

Eden Tesfaye: Thank you so much, Sara. Dr. Hughes, our next question is for you—and a reminder folks, Dr. Hughes is the Acting Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality. So, my question for you is, how will the addition of new social determinants of health (SDOH) assessment items in CMS programs contribute to advancing health equity?

Dr. Dora Hughes: Thank you for that question. We're excited about the inclusion of the new SDOH assessment items. Throughout our Quality Reporting Programs, we are focusing on living situations, which include housing stability, food, and utilities. And we think this is a critical part of advancing health equity through our program. By collecting data on these factors, we think that we will gain a more comprehensive understanding of the social and environmental factors influencing individuals' health outcomes, and this data is important. It will allow us to plan targeted interventions to address disparities and improve health equity among underserved populations.

Eden Tesfaye: Thank you, Dr. Hughes. Our next question is for the Deputy Administrator and Director of the Center for Medicare and Medicaid Innovations, Dr. Elizabeth Fowler. Dr. Fowler, why is CMS including a Decarbonization and Climate Resiliency Initiative in the Transforming Episode Accountability Model?

Dr. Elizabeth Fowler: Well, that's a great question, Eden. Air pollution, including greenhouse gas emissions, makes Americans sick and increases early mortality, and harms economic productivity. Additionally, climate change can exacerbate health inequities, many of which are more severe and affect disadvantaged communities that bear the brunt of climate-induced health risks from extreme heat, poor air quality, flooding, extreme weather events, and vector-borne diseases. Healthcare sector emissions are a significant contributor to emissions. In 2018, it accounted for 8.5% of total domestic greenhouse gas emissions. Several laws, executive orders, and funding initiatives encourage the reduction of greenhouse gases. This includes the White House executive order on tackling the climate crisis, the HHS (United States Department of Health and Human Services) Health Sector Climate Pledge, and other initiatives. And so, aligned with these initiatives, CMS proposes to collect emissions data from team participants who volunteer to participate in this initiative to monitor and assess data on hospital admissions and their impact on cost and quality, just as CMS monitors for other quality indicators that may impact beneficiary health. In addition to producing potential health improvements, this effort supports the Innovation Center's broader mission of lowering healthcare spending. Any reductions in hospital operating costs and spending due to energy efficiency and more efficient

health care delivery—especially in the case of anesthetic gases—will directly contribute to savings for CMS. TEAM is the first model to include a decarbonization and climate resilience element, and we anticipate looking for other opportunities in the future to include activities like these.

Eden Tesfaye: Thank you so much, Liz. Really appreciate it. Our next question is for Dr. Seshamani. Dr. Seshamani, how will CMS leverage the support of national and regional organizations to help spread the word about the Prescription Drug Part D cap and the Medicare Prescription Drug Payment Plan? When will the educational resources be finalized and available for folks to share with the people they serve?

Dr. Meena Seshamani: Thank you so much, Eden. We are really excited about the new programs that we have starting next year. As a recap, starting in 2025, seniors will now have a cap of $2,000 on their out-of-pocket prescription drug costs in Part D. This will be a relief to many seniors who are currently spending thousands of dollars a year on their drugs. Removing this burden will provide meaningful financial relief, and we are actively working to engage diverse groups in spreading the word about the program. We are also actively working on implementing the Medicare Prescription Payment Plan that will allow seniors to spread their drug costs throughout the year with monthly payments. This is not a program to cut costs, but it will help seniors who will benefit from it to pay monthly payments versus all at once for their annual drug costs. We recognize that engaging all of you, including patient advocacy groups, pharmacies, provider organizations, and many others, is paramount to robust education on this new program. We will launch national outreach and education efforts to ensure that interested parties have sufficient support and materials needed to communicate the availability and the nuances of this program in advance of Open Enrollment. CMS developed materials about the program intended for beneficiaries and these will be publicly available for all of you to use.

Eden Tesfaye: Thank you, Dr. Seshamani. Our next question is for Sara. Sara, what provisions in the Medicaid Access Final Rule will improve access to the quality of Home- and Community-Based Services?

Sara Vitolo: Thanks, Eden. To advance the President’s long-term care priorities, there's an Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers, and that executive order directs HHS to consider issuing regulations to improve the quality of home care jobs, including by leveraging Medicaid funding to ensure there are enough home care workers to provide care to the seniors and people with disabilities enrolled in Medicaid. We recognize the critical role that HCBS plays in enhancing the ability of older adults and individuals with disabilities to remain independent and integrated into their communities. To that end, this rule amends the system requirements and adds new federal HCBS requirements to improve access to care, quality of care, and beneficiary health and quality of life outcomes. Thanks.

Eden Tesfaye: Thanks, Sara. Really appreciate that. Our next question is for Dr. Hughes. Dr. Hughes, how does the nursing home staffing standards rule contribute to reducing health disparities across the board?

Dr. Dora Hughes: Thank you for that question. The nursing home staffing rule aims to reduce health disparities by ensuring that facilities maintain adequate staffing levels to effectively meet the needs of their residents. By mandating minimum staffing requirements, CMS seeks to improve the quality of care provided to residents from marginalized communities who may otherwise be at higher risk of experiencing disparities. Adequate staffing enables nursing homes to deliver timely and personalized care, promote resident safety, and address underlying health issues, ultimately leading to better health outcomes and reduced disparities among residents.

Eden Tesfaye: Thank you, Dr. Hughes. Dr. Liz Fowler, Liz, can ACO PC Flex participants use model payments to support providers, infrastructure activities, and coordinate behavioral health care? Can you share more on how this works?

Dr. Elizabeth Fowler: I can. As I mentioned in my remarks, ACO PC Flex includes a one-time advanced shared saving payment that helps cover costs associated with forming an ACO and administrative costs for model activities, essentially, infrastructure activities. And then, this monthly payment is designed to support advanced comprehensive primary care, which is intended to coordinate the majority of a patient's routine physical and mental health needs. The model aims to empower participating ACOs and their primary care providers to use more innovative, team-based, person-centered, and proactive approaches to care. Proactive, team-based approaches can include behavioral health integration, care management, and patient navigation services. We're really excited about what this means for primary care and think it's a really important model that will do a lot of good for a lot of beneficiaries.

Eden Tesfaye: Thanks, Liz. Dr. Seshamani, what plans does CMS have to expand awareness about the Extra Help program?

Dr. Meena Seshamani: So Extra Help is a program that provides prescription drug, or Part D, coverage, with no premium or deductible, for people who have limited income and resources. This program was expanded by the Inflation Reduction Act in January of this year. Some people qualify for Extra Help automatically, while others need to apply, and we estimate there are about three million people out there who are eligible for this assistance but are not enrolled. People in Medicare can apply for Extra Help any time before or after enrolling in Part D, not just during Open Enrollment season. So, we are continuing to spread the word about the program, and we rely on partners like you all to help us get the word out to those who may qualify but have not yet enrolled. We've also created resources in multiple languages to help people access the resources and toolkits that they need.

Eden Tesfaye: Thank you, Dr. Seshamani. Sara, the next one is for you. How will the Medicaid Eligibility and Enrollment Final Rule impact Medicaid redetermination, a.k.a. Medicaid Unwinding, a.k.a. Medicaid renewals, and all the different nomenclature for it.

Sara Vitolo: Of course. So, this rule makes critical changes that will improve how individuals receive and maintain their coverage. The changes finalized build on the key lessons learned from CMS' ongoing work with states as states continue conducting Medicaid and CHIP renewals after the end of the Unwinding Continuous Enrollment Period. In late 2023, for example, CMS found that strategies to simplify renewals and encourage retention—including several that formed the

basis for this rule, such as giving people more time to turn in their paperwork—led to more eligible people maintaining coverage in states that took up these options. Thanks.

Eden Tesfaye: Thank you, Sara. Dr. Hughes, our last question of the day is for you. What specific challenges do nursing homes face in meeting the new minimum staffing requirements? And how does CMS plan to work with them and address these obstacles?

Dr. Dora Hughes: Thank you, Eden. As we heard through many of our comments and our other stakeholder engagement sessions listening to beneficiaries and families, we understand that nursing homes, particularly those in rural areas, may encounter unique challenges in meeting the new minimum nurse staffing standard requirements. These challenges could include workforce shortages in many areas, financial constraints, and geographic barriers. CMS recognizes these difficulties and provides a staggered implementation timeline, as I mentioned earlier, along with the time-limited hardship exemptions to support facilities in achieving compliance with the minimum nurse staffing requirements. Additionally, you'll be hearing more about this during the summer—the agency will offer assistance through initiatives like the National Nursing Home Staffing Campaign that's under development now, which is aiming at helping with recruitment and retaining nursing staff.

Eden Tesfaye: Thank you, Dr. Hughes. Well, folks, that wraps up our Question and Answer session. Many thanks to all of our phenomenal speakers today. I don't know if you all noticed but there are a bunch of awesome women—Dr. Seshamani, Dr. Hughes, Sara Vitolo, and Dr. Liz Fowler, and of course our CMS Administrator, Chiquita Brooks-LaSure. We really appreciate their time, and we appreciate each of you for joining us today. And I also want to thank each of you on the call for your continued support, partnership, and dedication to the work that we all do together. We've accomplished so much. We all know that there's still much more to be done, and we're excited for the road ahead and everything we'll do together. Thank you, thank you, thank you. We hope you enjoyed today's call, and we hope that you have a wonderful rest of the day. Bye, now.