

Centers for Medicare & Medicaid Services
National Stakeholder Call
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Beth Lynk: Hello and welcome. Thank you for joining us for the national stakeholder call with the CMS leadership team. All right, it looks like we have quorum. So hello and welcome to the over 2300 people on the call right now. My name is Beth Lynk, and we are really excited to have you all here for this quarterly stakeholder call with CMS Administrator Chiquita Brooks-LaSure and the CMS leadership team.

This is our third quarterly Centers for Medicare and Medicaid Services National Stakeholder Call. I'm going to walk us through the agenda. We will have time for questions and engagement at the end of the call. Thank you to those who submitted your questions ahead of time, and we will go into the agenda in a moment. Before I do, just a few housekeeping items. As you may have seen, this call is being recorded, and I want to note that we thank you for accepting that the call is recorded and proceeding with us on this call. I want to note also that members of the press are welcome to attend, but note that all press and media questions should be submitted using our media inquiries form which may be found at [cms.gov/newsroom/media-inquiries](https://www.cms.gov/newsroom/media-inquiries). (<https://www.cms.gov/newsroom/media-inquiries>.) We will not be accepting live questions during the call; however, I do want to thank everyone for responding to our solicitation of questions beforehand and we have got a number of questions we will be answering live on the line with our leadership team.

Right now, everyone will see the agenda on the screen. The full agenda includes the Administrator, Chiquita Brooks-LaSure, the leadership team, Principal Deputy Administrator, Jon Blum, all providing updates on the CMS on key operations, and some of the key accomplishments that have been advanced during the first quarter of 2022. These presentations will be followed by a brief question and answer session where we will address some questions we have solicited from many of you. As we know, stakeholder engagement is a key part of the work for the Centers for Medicare and Medicaid Services. So, we are especially thankful to all of you for joining us on today's call and it is now my absolute pleasure to turn to Administrator Chiquita Brooks-LaSure for opening remarks. Administrator?

Chiquita Brooks-LaSure: Thank you so much, Beth, and to the entire communications team for your incredible leadership in making sure we are connecting with stakeholders which as you all know is just such a priority to the CMS leadership team. It's hard to believe it is almost May. It's been just a tremendous few months since we last met and discussed CMS's six strategic pillars: advancing health equity, expanding access, engaging partners, driving innovation, protecting program sustainability and fostering excellence. These six pillars are the guideposts every day as we work to deliver comprehensive, meaningful health coverage to the more than 150 million people we are serving across the three M's.

Even in these three short months we have made great strides towards achieving these pillars. Just to name a few, we have made huge leaps in expanding access. Our latest enrollment figures for Medicare and Medicaid, available on our website, showed that we cover 64.2 million people in Medicare and 85.8 million people in Medicaid and CHIP. We see increases every month, signs that our efforts are working to get people covered. The marketplace open enrollment closed with more than 14.5 million enrollments for 2022 coverage. As you all know, that is a record high, 21% more than last year, and we could not have done it without all of your help and hard work. Thanks to your leadership in your communities, we have more people enrolled in health coverage than ever. In March we celebrated the 12th anniversary of the Affordable Care Act. I cannot think of a better birthday gift than these historic gains in enrollment. Thanks to the American rescue plan, we are tackling the unfinished work of the ACA.

In the past quarter, we have made great strides in advancing health equity. We recently announced our health equity strategy in which we outline the central role that health equity plays across all of CMS. The plan aims to better identify barriers to coverage and access to care by leveraging several strategies, including closing gaps in access and quality, collecting data, and engaging with communities. I have been saying this quite a bit during the last couple of months, that the ACA was born out of an incredibly difficult time -- the great recession. I think we are in a similar moment today with the COVID-19 pandemic really giving us just such an "up close" lesson on what inequity in the health care system means to us as a country. We at CMS are laser focused on trying to advance health equity, across all levers. We know and we look forward to partnering with all of you who deliver care on the ground to the people that are served by our programs.

As you know, we are particularly focused on maternal health. Because we have a crisis in this country. It is something that we across the administration and certainly at CMS are engaged in trying to address maternal health outcomes, so that we can protect parents as well as children, babies, and young kids. We took significant steps in April to address the crisis by announcing a new state plan for states to expand Medicaid and CHIP coverage for 12 months. We have five states that have already gotten approval to extend coverage for a full year postpartum and we are working with more than one dozen states who are partnering with us on this important work. As you know, we have released our initial requirements for hospitals to be designated birthing-friendly. Thanks to the investments of the Biden-Harris administration, pregnant people and their families will be able to choose a hospital that has demonstrated commitment to maternal health.

We are also focused on expanding our support of aged and disabled loved ones in the community through expanding access to home and community-based services through our Money Follows the Person Program. And particularly of note, we posted a new funding opportunity for states that have not yet participated in the program in March.

In addition to all the things I have highlighted, we continue to do the core work of our agency by proposing updates to payment rates and policies for Medicare providers. We recently issuing several rules to support Medicare providers, drive high-quality person-centered care, and promote fiscal stewardship of the Medicare program. And we will continue to test and develop the new innovative payment and service delivery models through the Innovation Center that you will of course hear more about from Liz Fowler and our other Center heads.

These are just a few of the highlights of the last few months. There is so much more underway. Sometimes I marvel at the work being done at the agency. What we are trying to do is give you all a real sense of what our priorities are because we really want to make sure we are incorporating your perspectives, your experience, and particularly the experiences of those served by the programs into our initiatives.

As you also may have seen, we have released cross-cutting initiatives that the agency is working on and will be again partnering with all of you. So, these initiatives are integrating the three M's, Medicare, Medicaid, and CHIP. I love all 3 M's, they are all critically important. One of the things we want to do here is make sure we are making the programs as integrated as possible, and deviating only when there is a specific reason they should. Elevating stakeholder voices through active engagement is our second cross-cutting initiative. Behavioral health is our third. Drug pricing affordability is our fourth. Maternity care, our fifth. Benefit expansion, rural health, preparing the health-care system for a post-pandemic world, coverage transition. Really thinking about the unwinding of COVID-19 in a public health emergency rule. National quality strategy. Safety of quality and care in nursing homes. Data to drive decision-making and the future of work at CMS. All of these initiatives are high-level multiyear priorities at CMS. We call them cross-cutting because they are bringing our Centers and Offices together to leverage expertise across CMS and strengthen collaboration. We are pulling all the levers across all the programs in support of the six strategic pillars that guide us. Working with cohesive and coordinated strategies will strengthen our support for the people, providers, and other stakeholders that we serve.

I have already mentioned some of our cross cutting work, for example, to improve maternal health. This effort cuts across the agency and four of our strategic pillars: Advancing health equity, expanding access, innovation, and engaging with partners. We hit the ground running after President Biden's first State of the Union and are proud to be leading his charge to improve the safety and quality of nursing homes. It is one of our cross-cutting initiatives. We are working to set minimum staffing requirements, enhance oversight and accountability, and make facility ownership more transparent so that potential residents and their loved ones can make informed decisions about care. We also recently announced our national quality strategy, a cross-cutting initiative raising the bar for our high-value health care system to promote quality outcomes, safety, equity, and accessibility for all individuals, particularly those in underserved and under-resourced communities. Focusing on a person-centered approach to quality and safety, seeking to improve an individual's overall care journey.

Throughout the call and in the coming weeks, you will hear more about the important work we are doing and what we are doing to advance our 13 cross-cutting initiatives. All of you play a central role in the work. We are eager to hear your input on our strategic framework and initiatives. In addition to these quarterly calls, we have also been embarking on what we call the 3M Tour: Medicare, Medicaid and CHIP, and Marketplaces, visiting our CMS regions and perhaps a city or town near you soon. I have already had the pleasure of visiting New York. Last week I was in Cleveland, Chicago, and San Francisco, where I received valuable feedback about your experiences with our program and feedback on things like drug affordability and expanding access in hard to reach communities. Your voices will make CMS and our program stronger.

Before I introduce the leadership team joining me for the call, I wanted to thank you for your tremendous efforts. It is thanks to your selflessness and leadership that we have achieved so much over

the years. We still have so much more to do but I am truly looking forward to the work and am energized by the opportunity we have to change our health care system for the better.

As I think Beth started to outline but I will just mention, some of our key senior leadership team joining us for the call: Jon Blum is our Principal Deputy Administrator and Chief Operating Officer. Dr. LaShawn McIver, our Director of the Office of Minority Health. Dan Tsai, a Deputy Administrator and Director of the Center for Medicaid and CHIP Services. Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight. Dr. Meena Seshamani, Deputy Administrator and Director of the Center for Medicare. Dr. Lee Fleisher, Chief Medical Officer and Director of the Center for Clinical Standards and Quality. Dr. Liz Fowler, Deputy Administrator and Director of the Center for Medicare Innovation. Dara Corrigan, Deputy Administrator and Director of Center for Program Integrity. I'm so proud of this leadership team and thrilled to turn the floor over to the CMS Principal Deputy Administrator and Chief Operating Officer, Jon Blum. Jon?

Jon Blum: Great, thank you so much. Wanted to add to the comments to give some more perspective as to how CMS currently operates. We can go to the next slide. This is just a very small sample of the various metrics that we follow day to day. As you just heard, we are at record high total coverage. We treat these numbers very responsibly and are tremendously proud to say we are at an all-time high for overall coverage. CMS in 2022 will spend, just on the federal share, \$1.4 trillion, operating with a \$6.6 billion budget, half of it spent to really bring first rate technology to our systems. We have more than 6000 staff working tirelessly to run CMS programs. We will process 1.3 billion fee-for-service Medicare claims, contract with more than 1000 different Medicare health plans. We'll enroll more than 25,000 providers, 24 million calls we handle at our call centers and we will survey more of than 3000 nursing homes. This is just a very small sample of the day to day work that CMS does.

Going to the next slide, I want to share how we currently operate. These are 10 principles that will guide and really drive our work. First, CMS strives to have best in class operations and to make sure every beneficiary has the best experience and catalyze better health care system transformation. We want to serve as the overall model for how a health care system should be run. Second, we want to put the customer first and foremost. We are going to make sure that every Medicare, Medicaid and Marketplace customer or consumer has the overall best care and best CMS overall experience. We want people to have seamless transitions going from Medicare to Medicaid, Medicaid to Medicare, and to make sure that CMS really has one model, not separate models for our different programs. CMS will shift more systems to the cloud to reduce vulnerabilities. We want to integrate data to ensure we are making smarter decisions. We will contract better, bring down the error rates, hire a more diverse staff to really grow the CMS staff throughout the country, to ensure that we have strong networks, getting better data, that we are talking to more consumers. Lastly, to still recognize that we have to respond to the current pandemic. CMS will ensure that we are really supporting the entire health care system. These 10 principles will guide us, will make sure that we continue to grow coverage and give people the best possible care. With that, I will turn it over to LaShawn for the next presentation.

LaShawn McIver: Thank you Jon. Hello everyone. My name is Dr. LaShawn McIver and I am the Director of the Office of Minority Health at CMS. It is my sincere privilege to join you all today. In the next few moments, I'd like to share with you (1) our approach to advancing health equity, and (2) our progress on addressing what we believe to be a significant barrier to health equity in our programs.

First, I want to share a little information about the Office of Minority Health or CMS OMH. Our mission is to lead the advancement and integration of health equity in the development, evaluation and implementation of CMS's policies, programs and partnerships. Our vision is that all those served by CMS have achieved the highest level of health and well-being and we have eliminated disparities in health care quality and access.

So what is CMS's approach to advancing equity? For CMS, equity is defined as the attainment of the highest level of health for all people where everyone has a fair and just opportunity to obtain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. We are taking an integrated action-oriented, data-driven and stakeholder informed approach to advancing health equity. CMS OMH plays an important role in guiding these efforts across CMS programs. By providing executive level leadership and accountability, we are fostering an environment that advances equity by increasing collaboration and integration across the agency and framing CMS's approach to operationalizing equity in partnership with our communities, individuals and stakeholders.

What significant strides have we made in the first quarter of 2022? That's the second point I want to address today. As you know, this month is Minority Health Month, and I'm excited to announce our office released the CMS Health Equity framework on April 22nd outlining priority areas for our agency to consider as we operationalize equity across our programs and policies. During the first part of 2022 we have made progress on a particular priority in our Health Equity framework that stakeholders have asked us to focus on, that is expanding collection and stratification of data across our programs, thinking about health equity focused measures and working to increase the availability of, and access to, CMS data for researchers and our external partners. We understand that without data, we cannot see disparities or know who is most impacted and where the gaps in quality, access, and outcomes are. To that end, we have taken action as an agency under the guidance of agency leadership and the CMS Advisory Council on Equity. We formed a Health Equity Data Workgroup, comprised of representatives in all major Centers and Offices in CMS. We are collaborating across the agency to increase the collection of standardized demographic and social determinants of health data elements across our health insurance programs and are actively working on important efforts to achieve this goal. In addition, our office announced in February the expansion of our minority research grant program that will allow CMS OMH to fund more Minority Serving Institutions access to CMS data to help inform our efforts to advance health equity within our programs.

So, in closing I want to thank you for the opportunity to share just some of the incredible work underway to advance health equity within CMS and I look forward to our continued partnership on this important journey. Now I go to Dan Tsai, Deputy Administrator and Director for the Center for Medicaid and CHIP Services.

Dan Tsai: Thanks LaShawn, I appreciate it. Thank you all for engaging with us as we have started doing site visits more, and being out with providers and hearing directly from a range of direct beneficiaries, advocates. Thank you all for the work you do every day. They always say Medicaid is excellent, cool, awesome, and we're glad you're here with us. I am just going to run through a few specific pieces that are not exhaustive given time.

First, many of you have been engaged with us on preparations for when the public health emergency ends, how to maintain coverage and support for folks as we unwind along with the states from the public health emergency. That remains the top operational priority for the Center for Medicaid and CHIP Services along with our many colleagues across CMS – to make sure we are doing everything possible with our partners at the state, provider, plan, advocate, and broader community level to maintain coverage for folks, whether that be in Medicaid, Marketplace, employer sponsored coverage, etc.

Second, around coverage and access, we've continued to engage substantially around demonstrations making sure that policies that have the effect of restricting coverage between work requirements and premiums for individuals under a certain amount of the poverty limit – are no longer in place -- that we can affirm coverage through the objectives of Medicaid and that we are partnering with the states really as an open-door for any state that hasn't yet expanded Medicaid to consider options to do so. Similarly around access, many of you responded to our Request for Information where we are really keying on determining how best to ensure there is a sufficient, consistent floor for access across the country on Medicaid, including not just physical health care services but behavioral health, home and community-based services, and many of the workforce topics that are related.

Next, equity is a major focus as the Administrator mentioned and you just heard from LaShawn. One element of that is our work across CMS – we're really think about the social determinants of health and the necessity of addressing that as part of improving the disparities in health outcomes and prioritizing work with states and others on better stratifying and measuring where there are health disparities.

Next is maternal health. The Administrator mentioned some of the very exciting pieces around quite a number of states having taken up the option to expand 12-month post-partum coverage. It has been like popcorn where things are coming up all over the place. There are states expanding that we don't even realize until we chat with folks. We are excited for that and we hope that as many states as possible take that up. And we're highly engaged from a technical assistance standpoint to make sure that the quality of care in the post-partum period is as high as possible.

For kids and youth behavioral health, we are at a crisis point certainly around the kids' side and broader, and there is a substantial amount of work there around school-based Medicaid, how we think about the crisis system, partnering with our colleagues at SAMHSA for standing up 90-day crisis lines across the country.

And then home and community-based services as the Administrator mentioned, we are excited for more opportunities to fund more states to really take up novel opportunities through the Money Follows the Person program, including expanding the use of those dollars around housing supports and other things to transition folks out of institutional settings.

Finally, day to day, we are rolling up our sleeves with states, providers, plans and advocates really to get much of the challenging day-to-day work done in service of the 86 million folks that we serve. Thank you all for that and with that I am passing it to Ellen.

Ellen Montz: Thanks so much, Dan. I'm on several pieces of technology so hopefully you can both hear and see me. I'm very excited to bring a few updates from CCIIO today. Health equity is certainly a central theme for today's call, and it is certainly the foundation of how we approach our work at

CCIIO. All three of the areas that I will highlight in my remarks today are central to our strategy to advance health equity – that’s increasing our Marketplace enrollment particularly for underserved populations, improving the foundation for successful coverage transitions across CMS programs, and third, ensuring consumers understand their rights and can access the new protections against financial harm through our implementation of the No Surprises Act.

First, I’ll turn to this year’s historic Marketplace enrollment that the Administrator mentioned earlier. The Special Enrollment Period and the most recent Open Enrollment Period have made the resounding point that if you make health care more affordable, and tell people about it, more people get covered. I specifically want to highlight that this year through our largest outreach and enrollment campaign, an important investment in Navigators and an incredible partnership with many of you on this call, we worked tirelessly to ensure communities that have historically been disproportionately uninsured or underinsured, knew about the affordable coverage options available. And nationwide, 14.5 million Americans signed up for 2022 health care coverage through the Marketplace during this Open Enrollment period, which as mentioned is a 21% increase year-over-year and also a 17% increase in new consumers. We know that these historic gains in coverage were also driven by historic gains in affordability through the American Rescue Plan Act subsidies. Like you, we share the hope that Congress extends these subsidies, particularly in light of our public health emergency unwinding.

Next I want to talk about our work in coverage transitions, particularly across Medicaid and the Marketplace. The end of the public health emergency, that date is unknown, but I do want to highlight the foundational work our teams have done across CMS along with our state-based Marketplace partners, State Medicaid agencies, Departments of Insurance and many of you on this call to build a stronger foundation for coverage transitions in preparation for the end of the public health emergency and for the future. We have a long way to go to realize the experience we all want for our consumers across programs, but every increment matters. Our work here is focused on three areas with the central goal of minimizing potential coverage loss wherever possible. First, we are focused on systems improvements and policy flexibilities. Our second area is really focused on stakeholder engagement with folks like you. We know that partnership and our work together are really going to help drive successful transitions across coverage to make sure people find their way and end up in the right coverage for them. Finally, we are working particularly at CCIIO with the CMS Office of Communications and preparing for a large-scale outreach enrollment campaign to get folks to the Marketplace for coverage. We have been shown time and again that when folks actually come to [healthcare.gov](https://www.healthcare.gov) or a state-based marketplace and start the application, they end up in quality coverage, and we want to make sure they know how to get that coverage.

The last thing I will mention is I want to spend a moment on our work on implementing the No Surprises Act and those consumer protections that launched on January 1. First, commercially insured consumers are protected against surprise medical billing in emergency care, nonemergency care from out-of-network providers at in-network facilities, and area ambulance services from out-of-network providers. Additionally, new consumer protections came online January 1 that better equip uninsured and self-pay consumers to understand their responsibilities when seeking medical care and provide an avenue to dispute those charges when they’re higher than anticipated. We continue to work on implementation of these important consumer protections, and we’re focusing on consumer education, technical training for providers and issuers, as well as continuing to refresh our content to better reach our partners and indeed, partnering with all of you to get the word out. For this work and

additional work on coverage and other items I mentioned, I want to say thank you again for your continued engagement and commitment to ensuring folks have coverage that I have highlighted today. Now I will turn it over to my friend and colleague, Dr. Meena Seshamani, for her remarks on Medicare.

Meena Seshamani: Thank you so much, Ellen, and it's great to be with you all today. Again, I'm Meena Seshamani, Director of the Center for Medicare, and I'm very excited to join to talk about our work and what we have done over the last quarter where we have announced several policies that drive towards our strategic pillars of advancing health equity, expanding access to coverage and care, driving innovation, and engaging with our partners.

First, on advancing health equity, just last week we published a piece in the Journal of the American Medical Association describing the vision of how to leverage Medicare to advance health equity. Importantly, this is comprised of two buckets, improving operations and then implementing specific policies to advance equity. With improving operations as many of you know, if the system doesn't work, it's our most vulnerable who fall through the cracks. And so every day, we approach the operations of the Medicare program through that lens of equity to make sure that we are supporting all 63 million people who rely on the program. Making sure that care is comprehensive, easy to navigate and reliable, and this includes the oversight that we do as well as the day to day operations of our claims processing, etc. The other piece of this is really engaging to hear from people that we don't always hear from. To go out and has been mentioned by my colleagues, to go to the front lines to engage with people who maybe haven't been heard. Recently, I did some side visits with small providers who are engaged in some of our total cost of care models. One in a rural area with significant Native American population. Another caring for an intellectual and developmentally disabled population to be able to really understand where the opportunities are where we can all work together to serve the people in the Medicare program and advance equity. The second bucket here is on implementing some specific policies. You may have seen that we recently sought comment on a new health equity index in Medicare Advantage to enable us to identify and reward plans that deliver high-quality care to underserved populations. We are also seeking comment on how social risk factors could be incorporated into DRG payments in our inpatient prospective payment rule so that we can understand where there are additional resources that might be needed to provide good care. We are also working closely with our colleagues in the Center for Clinical Standards and Quality on how CMS should think about health equity in quality measurement, including soliciting comment about how we could stratify measures to identify disparities and potentially encourage their reduction. You will hear more about this from Dr. Fleischer on these efforts.

The second bucket is around expanding access to affordable coverage and care. As you may have seen, expanding access has been critical for the COVID-19 response and starting this month for the first time in history of the Medicare program we are paying for an over-the-counter service and test at no-cost to beneficiaries. So people in either original Medicare or Medicare advantage are now able to get eight over-the-counter COVID-19 tests at their participating pharmacies per calendar month at no cost to them. This is an important step in improving access to testing as we continue to fight COVID-19 and we are thankful for all of your partnership in enabling this to happen, both from the pharmacy and provider side of participating in the initiative, and for all of the educational outreach that has gone into this to make sure people can take advantage of it. Beyond COVID-19 we just announced a proposed rule that really puts people at the center of what we do, with tangible improvements to make it easier for people to enroll in Medicare and eliminate delays in coverage. CMS is proposing to provide Medicare

coverage the month immediately after Medicare enrollment -- reducing the waiting period before Medicare coverage starts. The rule also proposes special enrollment periods that will be available for individuals who are unable to enroll due to exceptional conditions, such as people who are affected by a disaster, people who are formerly incarcerated, and for those who lose Medicaid eligibility which, coming back to something the administrator said, is especially important as we think about the public health emergency and the unwinding.

The next bucket around driving innovation and promoting high quality and person-centered care, this month we are celebrating the 10th anniversary of the Medicare Shared Savings Program Accountable Care Organizations. As both a practicing physician and Director of the Center for Medicare, I see firsthand how this program is a win-win for people with Medicare and the people who provide care to them. As I mentioned, I recently had the pleasure of visiting two ACO's serving underserved populations to really see firsthand how they are innovating, how they are incorporating social needs and care management into the care they provide to their populations. We must capitalize on lessons and successes like these. By increasing ACO participation and accelerating care transformation, Medicare can continue to lead the way for payers, health care providers, and purchasers across the country to advance accountable care.

I think with all of this, it comes back to all of you. A key theme of this work and what my colleagues are talking about is that we cannot be successful without your ongoing partnership, and so, we look forward to our continued work with you. With that, I will turn it over to Dr. Lee Fleisher, Chief Medical Officer and Director of the Center for Clinical Standards and Quality.

Lee Fleisher: Thank you so much, Meena. It certainly has been a busy time for CCSQ. We're coming off another wonderful CMS Quality Conference two weeks ago. Thank you to anyone on today's call who attended. In addition to the excellent discussions on improving quality and safety, we had an opportunity, as the Administrator mentioned, to unveil both the CMS National Quality Strategy and the CMS Behavioral Health Strategy, both of which we are looking forward to accelerating over the coming months. Lastly, in partnership with components across the entire agency, CCSQ has begun work in earnest on many of the initiatives outlined in President Biden's vision for improving quality and safety in nursing homes, which we will talk about in just a few moments.

I'll start with one of the more unique decisions we have recently released. The final national coverage determination for monoclonal antibodies directed against amyloids for the treatment of Alzheimer's disease. The final decision ensures access to and coverage for Aduhelm and other drugs in the class that received accelerated approval through the FDA or NIH-approved clinical trials across a broad scope of clinical care settings. The decision also supports innovation and certainty of coverage by creating a long-term coverage pathway for new drugs in this class that obtain FDA approval, without requiring a new national coverage determination. We will continue monitoring the future developments in this class of drugs and are committed to exploring ways we can improve care for people with Alzheimer's disease.

On the inpatient front, CCSQ included a number of key initiatives and comment solicitations as part of the inpatient prospective payment system proposed rule released on April 18. For example, we had proposed three new social determinants of health for quality measures for hospitals, and we are seeking

comment on a cross-setting framework to advance health equity by identifying and addressing disparities, as my colleague Dr. Seshamani mentioned. We have also proposed adding a birthing friendly hospital designation to Care Compare and are seeking feedback on ways we can advance equity and reduce disparities in maternal care. Finally we are soliciting comments on opportunities to address climate change across care settings.

In the post-acute care space, CCSQ included several proposals and requests for information within the skilled nursing facility prospective payment system proposed rule as a part of advancing the President's vision of improving safety and quality of care in the nation's nursing homes. We are specifically seeking comment on establishing a minimum staffing standard within nursing homes. We are also taking advantage of our new authority to expand the skilled nursing facility value-based purchasing program by proposing to add three new measures. As part of this expansion, we are also seeking comment on including a staff turnover measure within the skilled nursing facility value-based program in future years. I would now like to turn it over to my colleague, CMS Deputy Administrator and Director of the Centers for Medicare and Medicaid Innovation, Dr. Liz Fowler. Liz?

Liz Fowler: Thanks so much, Lee. And thanks to everyone for joining us today and all of those who are helping us to make the CMS vision a reality on a daily basis. We are grateful for your work and your dedication in implementing CMS policies and programs on the ground in pursuit of better health care for all people.

Looking back at the first quarter of 2022 at the CMS Innovation Center, it's hard not to start by mentioning ACO REACH. In February, we announced that the Global and Professional Direct Contracting Model, the GPDC, will be transitioning to the Accountable Care Organization model, called ACO REACH, which stands for Realizing Equity, Access and Community Health -- a redesigned model that aligns with the values of the Biden-Harris Administration. The GPDC Model will continue in its current form until the end of the year and then we'll transition to the ACO REACH Model on January 1, 2023. The ACO REACH model includes a strong focus on health equity and closing disparities in care; an emphasis on provider-led organizations; stronger beneficiary protections and increased screening of model applicants; greater transparency and data sharing; and stronger protection against inappropriate coding and risk score growth. Between now and the end of the year, CMS will operate the GPDC model with more robust and real-time monitoring of quality and costs. Participants that fail to meet model requirements could face corrective action.

Additionally since the start of 2022, the CMS Innovation Center has also made great strides with other models. In March, we announced the request for applications for the Medicare Advantage Value-Based Insurance Design Model with key updates that include a voluntary Health Equity Incubation Program. We are excited about the innovative approaches we're testing with the second round for the Kidney Care Choices Model, and that request for applications, which cares for a particularly vulnerable population. Finally, the Part D Senior Savings Model announced its calendar year 2023 Pharmaceutical Manufacturer RFA and its 2023 Part D Plan Sponsors RFA.

Embedded in all of this work is an unwavering commitment to centering health equity in everything we do. From application and selection processes to technical assistance with our models, we are considering all angles to ensure our models are improving care in the communities that need it most.

Thanks again for being here and for the essential role that you are playing in providing all people with quality, affordable, person-centered care. With that, I will turn it over to Dara Corrigan, Deputy Administrator and Director of the Center for Program Integrity to talk about their accomplishments from quarter one.

Dara Corrigan: Thank you, Liz, I really appreciate the introduction, and I'm very happy to be here today to talk to you about some of the work at the Center for Program Integrity. The Center for Program Integrity and the mission we seek to fulfill every day is to protect the beneficiaries across all CMS programs from harm and to safeguard taxpayer dollars. As you heard from the other Centers, we are like a thread that goes through the Centers to really make sure we are thinking about vulnerabilities in the system and how to address them. Not only through law enforcement partnerships and the efforts we make internally, but it is also really looking for vulnerabilities and how we can address them within CMS with our policies and change we can make.

One of the accomplishments for Q1 of this year I wanted to highlight was a program that many of you may not know about. It's something called the Open Payments Program, and it is a program that we administer in the Center for Program Integrity. It goes along with our mission of trying to be transparent to help beneficiaries get the best health care possible. This program makes information available to anyone publicly, about payments that drug and medical device companies make to physicians in teaching hospitals. Like I said, anyone can access the database and it is very simple. Go in, put in your physician's name and you can see if they've received any payments from pharmaceutical or device companies. Our hope is that people can use this information to make the best decisions for them, but in thinking about this program over the last year or so, we wanted to expand the information that you could receive about other providers. It means we have expanded to new provider types this year including, for example, nurse practitioners and certain types of clinical nurse specialists. We also updated the definition of what needs to be reported so that you can know, whether or not, if there are loan forgiveness payments being made or other types of payments you might be interested in. We know that a lot of researchers and investigative journalists use the database and we would really want to expand the number of beneficiaries and stakeholders who can access the information to best utilize that information for health care decisions.

As you might imagine, a large part of our role has been to evaluate waivers and flexibilities given during the public health emergency, and to help assist in going forward to make sure that any program integrity risk that we identify can be addressed going forward. One of the areas where we saw particular vulnerabilities was with certain types of orthotics and durable medical equipment. It's not a new problem, it's an old problem, but we saw new and innovative ways people use to use the waivers and flexibilities during the pandemic. We issued a Federal Register Notice in January of this year advising people that in the next 90 days we will be re-instituting face-to-face requirements, which can be a telehealth visit, combined with prior authorization for certain orthotics and durable medical equipment. We think that this type of proactive approach is the best one to take within program integrity and we are insuring the education needed is provided as soon as possible.

One of the other things that we did in the first quarter was to publish with the Health Care Fraud Prevention Partnership, which is a group of not only federal regulators but also state regulators and private pay, which works together in partnership to identify fraud, waste, and abuse schemes so that we

can work together to use the data to help each other across the board. In connection with the Stanford School of Medicine, we put together a report that traces how fraud, waste, and abuse evolved during COVID-19. I would like to describe it as not new, but a pivot to where the opportunities are.

Lastly, because I know we want to get to questions, we continue to collaborate very closely with law enforcement to eliminate fraud, waste, and abuse. Some of the schemes we have looked at and taken action against are related to fraud related to telemarketing. It happens in a lot of different ways. Identity theft was rampant during COVID-19 and there was billing for many tests that were not required. We're taking action and have taken action to make sure those vulnerabilities are closed. I look forward to speaking to you again next quarter about our progress and I would like to turn it over or back to Beth Lynk. Thank you very much for your time.

Beth Lynk: Thank you so much, Dara. Thanks to all of the leadership team. As you can tell, we have been really busy here at CMS and there is quite a lot going on. We are going to turn to questions. I will note that we might not be able to get to all of the pre-submitted questions, just for time sake, but we will do our very best to answer as many as we can. First question, I want to turn to our fearless leader. Administrator, this one's going to you. Last week you were in Chicago meeting with nursing home staff and over the past weeks you have been talking with nursing home staff and residents, as well as members of the nursing home industry. One of the things you have been hearing and one of the questions we received is questions about staffing and shortages. I wanted to ask you or one of our participants wanted to ask you how will CMS address the shortage of home health aides in nursing home staffing in our work to advance the quality of nursing home conditions?

Chiquita Brooks-LaSure: Thank you so much for the question. As everyone knows, this has been a long-standing issue, nursing home staffing, as well as making sure people are getting care in the most appropriate setting at home and in the community. One of the things we have been hearing very much over the last six months is just about how important staffing is to residents, the people in nursing homes hearing directly from staff, and how closely linked quality is to sufficient staffing in nursing homes. So we, as an Administration and certainly at CMS, we really are trying to have a comprehensive approach to our quality issues and work with all of our partners. One of the things that was so exciting about our trip to Chicago was really working with the state, who also has been working for many years in trying to address nursing home quality and the initiatives coming out of Illinois and how they are structuring their Medicaid payments for nursing homes. That is something I think we can build on with other states. We believe- shopper of the world- have a Request for Information and we really welcome stakeholder input into this discussion because one of the things, which I hope is coming through, is we really want to engage all parts of stakeholders to address these issues and we want to make sure we are highlighting training and the pipeline and all of the things that will help make sure we have sufficient staff for the needs of our health care system.

Beth Lynk: Thank you so much, Administrator. Our next question -- and for time I am going to combine a couple of questions we got -- is going to be to Dan Tsai, Ellen Montz and Dr. Meena Seshamani. We have been hearing from many of you that you are excited about our efforts to increase equitable access to affordable health care coverage, but a number of folks are looking at what is going to happen when

eventually at some point the public health emergency ends. And so, to Dan and Ellen particularly, how is the Administration ensuring continuity of coverage, particularly for people who currently have access to Medicaid coverage, as well as essential services like telehealth when the COVID-19 public health emergency ends? And similarly, to Dr. Meena Seshamani, how are you looking at that as we do our planning and our engagement?

Dan Tsai: Thanks Beth. Maybe I'll start and kick it to my colleagues. I think as I noted, this remains at the top of our list from the operational policy perspective. We want to make sure everyone possible maintains health care coverage through Medicaid, Marketplace, Medicare and employer-sponsored coverage. That involves essentially pulling out all the stops. The immense amounts of work and guidance we have had from a CMS standpoint, working with our partners on the state and local level, really encouraging folks to take as much time as possible over effectively 14 months, whenever the public health emergency ends, to thoughtfully and carefully go about redetermination to make sure that all the statutory and regulatory requirements are really met, including maximizing things where folks can administratively renew someone without having to miss a piece of paper in the mail. Those efforts, including day-to-day, one-on-one discussion with the states identifying operational issues, and partnering with Ellen's team to try to make sure that those transitions from a systems and IT and operational and policy standpoint were managed. We are engaged in the community including health plans and others to really support direct outreach to individuals and on things outside of eligibility that we really are encouraging states to take advantage of or have easy off ramps to have a glide path around things like telehealth and other flexibilities that some states adopted during the pandemic. We think many of those pieces are the silver lining of the pandemic and we would like to see continued on a permanent basis. Ellen, anything from the Marketplace standpoint?

Ellen Montz: Thanks Dan. I just want to echo what Dan said about taking an "all hands on deck" approach to ensuring successful transitions, where coverage transitions are the rights step for a former Medicaid member. Our approach to helping ensure that folks do successfully transition who are no longer eligible for Medicaid to Marketplace coverage is multipronged. First, we are looking at all of our policies and our systems to make sure we have the most streamlined process we can create for a consumer to come over and apply for coverage on healthcare.gov. Second, we are really working on all of our partnerships to make sure that the folks who need to be transitioned over to Marketplace coverage have the help they need to do that, which could mean understanding that it's there or the ability to help take folks through their applications. The third piece again, that's really working across CMS to ensure that we are effectively doing our own individualized outreach to folks that we know are no longer eligible for Medicaid and are eligible for Marketplace coverage.

Meena Seshamani: I think I will add for the other M "Medicare," as I mentioned earlier we just put out a rule that proposes a special enrollment period for people who lose Medicaid eligibility. So continuing on this theme, we want to make sure that people who may come off of Medicaid have appropriate coverage to go to and where that coverage is Medicare, we are proposing a special enrollment period to enable enrollment in Medicare. So, I think there is access to care from both the coverage side of being able to get into the program and then, I think Beth you had also mentioned about telehealth and some of the innovations that have happened during the pandemic that I can very quickly touch upon. Where

there have been areas with a statute, for example, following Congressional action we made permanent, telehealth payments for behavioral health. So, we are looking at where there are those opportunities either by change in statute that enables or where there might be opportunities in what we have evaluating where the innovations have occurred during the pandemic, where they can really advance health equity, drive innovation as we have been talking about, and promote good fiscal stewardship of our program. That is ongoing work that we continue to do as we move forward through the pandemic.

Beth Lynk: Thank you so much. I acknowledge that we are a little over time, I think we might have time for two more questions, so I will quickly take us through the final questions. The next one is to Dr. Liz Fowler. Specifically, we had a question about Physician Focused Payment Models, noting that they can provide a tailored solution for specific conditions in the patient population in both Medicare and Medicaid, and serve as a solution to addressing health inequity. Are CMMI and HHS planning to reengage with stakeholders and the PTAC to more seriously consider these types of proposals?

Liz Fowler: Thanks Beth, and I will try to answer quickly, as I know we are out of time. We absolutely continue to engage with stakeholders. Just today we had a listening session on an advanced primary care model, and we continue to regularly engage with the Physician Focused Payment Model Technical Advisory Committee (or PTAC). As I mentioned in the national stakeholder call earlier this year, as we implement our strategy and we're examining our model portfolio, a core part of that strategy is looking at creating a more streamlined model portfolio, and we're committed to having a more cohesive articulation of how all the models fit together. As we launched our strategy refresh, we collaborated closely with PTAC to share information about our direction and priorities. The presentations at the last PTAC meeting aligned with so many of the thorny questions we were also asking at the CMS Innovation Center, like how to define important terms like total costs of care, what's the role of specialty care in value-based care models, and how to harmonize our models to make sure they are working together. So, we are looking forward to working closely with PTAC and also with our colleagues at the Assistant Secretary for Planning and Evaluations Office at HHS, as the issues we seek to solve require really all of us thinking and working together.

Beth Lynk: Thank you so much, Dr. Fowler. We are going to turn the last question to our Principal Deputy Administrator, Jon Blum. I do want to note a few questions we won't be able to get to but just noting that we do hear you. We heard some additional questions about the public health emergency and when it ends at whatever point, what are we looking at in terms of that process? We will follow up there. Additional questions about provider services and payments in the Medicare program. Questions and interest in how CMS is advancing health equity with regard to data collection and our priorities in the health equity framework, really directing folks to the resources available online, as well as the questions related to how we are advancing work on continuing to strengthen Americans access to affordable quality health coverage as indicated and directed by the President in his recent Executive Order. We will be following up on those but for time I would turn our last question to our Principal Deputy Administrator, Jon Blum. This one is about advancements in technology that have produced efficiencies and lowered unit prices in every industry except health care. The questioner asks, broadly speaking, the introduction of technology within health care has served to increase

unit prices. What is CMS doing to turn that around to provide greater efficiencies that benefit all consumers through lowered prices that then translate to lower costs of coverage?

Jon Blum: Thanks Beth. One of our key themes we've heard during all of the different presentations today is we want to transform the health care system, and one of the flaws of our traditional fee-for-service payment system is they pay for more costs. We want to change the health care system to focus on value, focus on total cost of care that we think can have much stronger data that if we change how we pay for care and focus on the total quality and total cost of care, that it will promote technology coverage for those things that truly have the best value. By changing the payment system, we very strongly believe we will have the best opportunity to get better value, better cost and better quality of care.

Beth Lynk: Thank you so much, Principal Deputy Administrator. Now I'll turn back to our fearless leader, Administrator Brooks-LaSure, to give us the final word.

Chiquita Brooks-LaSure: As a team we so much appreciate your engagement with us. We will continue to have the lines of communication open. We really welcome your feedback through our processes of rules, regulations, and guidance, but of course through meetings and our visits across the country. Thank you so much for taking the time with us and we look forward to our next discussion. Thanks, Beth.