Centers for Medicare & Medicaid Services
National Stakeholder Call with CMS Administrator
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Eden Tesfaye: Welcome to the over 2,000 people who have joined us today for the CMS's first National 2024 Quarterly Stakeholder Call. My name is Eden Tesfaye and I'm an Advisor to the CMS Administrator for External Affairs. Today, I'm going to walk through the agenda and then turn things over to our speakers, but before I do that, I have a couple 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 always welcome to attend these calls, please note that media questions should be submitted using the 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 questions beforehand, and we will be addressing a few of those today. Everyone should be able to see today's agenda on their screen. We have a full agenda that includes the CMS Administrator, Chiquita Brooks-LaSure, her leadership team who will highlight CMS's key 2023 accomplishments, and then give some previews into how our 2024 priorities are advancing CMS's strategic plan. These presentations will be followed by a Question & Answer session, as I mentioned above. And with that, I'll turn it over to our fearless leader, CMS Administrator Chiquita Brooks-LaSure. Administrator, over to you.

Chiquita Brooks-LaSure: Thank you so much, Eden. And just a huge hello and thank you to everyone. It's my pleasure to start the new year off with you, our partners that provide care to Americans across the country. You enroll people in coverage, and you advocate for those who are served by our programs. We want you right alongside us this year as we continue to advance our vision of better health care for all people across the three Ms: Medicare, Medicaid and CHIP, and the Marketplaces. Before we get to 2024, I want to take a moment just to celebrate what we achieved together since we last gathered. You helped 160 million people connect to affordable, comprehensive, and meaningful care, and that's worth celebrating. First, we made historic strides in making health care affordable. It's one of the Biden-Harris Administration's top priorities to help people afford the health care they need to thrive. Thanks to those investments, health care coverage is now more affordable and more accessible than ever. That's especially true for people shopping for coverage on the Health Insurance Marketplaces. They're finding plans with truly affordable premiums and co-pays, and they're signing up. I know so many of you have worked hard to connect with our uninsured, underinsured, and hard-to-reach communities during this Open Enrollment. For your countless hours of work, I want to say thank you. Your efforts are paying off. We closed yet another record-breaking Health Insurance Marketplace Open Enrollment with over 20 million enrollments and counting. That's three Marketplace enrollment records in three consecutive years. And more importantly, it's a record number of people who will now have access to affordable, comprehensive health care coverage. We're also tackling the cost of prescription drugs. Through the Inflation Reduction Act (IRA), we're delivering

meaningful savings to people with Medicare. Thanks to the law's landmark reforms, we're already lowering costs through free recommended vaccines and caps on insulin costs. And for the very first time in history, drug companies can't hike their prices faster than inflation without having to pay a rebate to Medicare. Medicare now has the authority to directly negotiate lower drug prices for conditions such as cardiovascular disease, diabetes, Crohn's disease, and rheumatoid arthritis. And people with Medicare have a cap on their out-of-pocket prescription drug costs. Affordability will always be a guiding light in our work together.

I'm also grateful for your work on tackling the nation's maternity care crisis in 2023 by expanding Medicaid and CHIP access. We are now up to 43 states plus DC and the Virgin Islands with expanded postpartum coverage to 12 months. On behavioral health, Medicare is now covering Marriage and Family Therapists, and the Innovation Center just launched a model to improve the quality of care and health outcomes for Medicare and Medicaid enrollees with moderate to severe behavioral health conditions, including substance use disorders. I'm especially excited to announce that as of last week, over 11,000 Mental Health Counselors and over 1,700 Marriage and Family Therapists have already enrolled in Medicare to provide these vital services. We are working to ensure that people are getting the care they need and also to reduce the stress on doctors and nurses which contributes to provider burnout and ultimately prevents people from getting the care they need. We just finalized our policies to reduce unnecessary administrative burdens like challenges with the prior authorization process. It is critical that prior authorization not be an impetus to keeping people from getting care but serve as a tool to improve their care. You'll hear more about the final rule during our call today. These changes are reflective of your feedback to us about the pressing issues that happen in the lives of providers and Americans, and we are listening. 2023 was nothing short of extraordinary, and thanks to all of you for the work that you did to help us get there.

We have an ambitious agenda for 2024. All of our work is focused on working to ensure that all the people covered under our programs have the opportunity to obtain their optimal health no matter what they look like, where they live or how much money they have. Health equity will always be a cornerstone for our programs and initiatives by focusing on getting everyone eligible into coverage and ensuring that their coverage is meaningful -- that children get their vaccines and needed mental health services, young adults and parents get preventive and primary care, and seniors can afford their prescription drugs and care in the most appropriate setting. Thank you. Please enjoy the rest of the call. I will turn the call over to Dr. Meena Seshamani.

Dr. Meena Seshamani: Thank you, Administrator, and it's great to be here with all of you today. Happy new year. I'm Dr. Meena Seshamani, Deputy Administrator and Director of the Center for Medicare. In 2023, our team in the Center for Medicare delivered on historic work to advance health equity, expand access, drive innovation, foster excellence, and protect Medicare sustainability -- all in partnership with you. In short, Medicare is better than ever and there is more to come. I'd like to provide some highlights from the past year. We are right on schedule with our implementation of the drug law, the Inflation Reduction Act. To build on some of the key points that the Administrator mentioned, effective January 1 of this year, we expanded Medicare's Extra Help Program, which helps people with low incomes pay for Part D coverage. People with Medicare can find more information at medicare.gov, 1-800-Medicare, and they can apply for Extra Help with Social Security at ssa.gov/extrahelp, or by calling 1-800-772-1213.

This is so important because we estimate that there are about three million people who are eligible for Extra Help who may not yet be enrolled, so please get that word out. Also, this year, people enrolled in Part D who had very high drug costs will get some relief. Once enrollees reach a certain threshold on paying for out-of-pocket costs, called the catastrophic phase, they will no longer have additional cost-sharing or co-pays at the pharmacy. We are also continuing our implementation of the $2,000 out-of-pocket cap for Medicare Part D for 2025, including a provision that allows people with Medicare to pay out-of-pocket costs in monthly payments that are spread out over the year. Collectively, these reforms provide needed relief to millions of Americans who rely on prescription drugs to stay healthy.

In 2023, our team also finalized policies that continue to transform care towards a Medicare that recognizes people with Medicare as whole persons with their own families and unique life stories. As it's been increasingly clear that we must improve access to behavioral health services, we finalized some of the most significant changes to promote access to behavioral health in the history of the Medicare program. Following congressional action, Marriage and Family Therapists and Mental Health Counselors--including Addiction Counselors--are now permitted to enroll in Medicare. This means that more than 400,000 additional practitioners could enroll in the Medicare program to be able to independently and directly care for people with Medicare. We also finalized new payments for Community Health Integration and Principal Illness Navigation services. And we increased payments for psychotherapy and, following congressional action, created a new benefit for intensive outpatient therapy called the Intensive Outpatient Program. For people with Medicare Advantage, we proposed a requirement for plans to include an adequate number of behavioral health practitioners in their provider networks. On Medicare Advantage, it remains strong and thriving. We recently proposed guard rails to help people with Medicare elect and enroll in coverage options that best meet their health care needs by preventing plans from engaging in anti-competitive steering of prospective enrollees. We cracked down on misleading marketing schemes, rejecting more than 1,000 misleading ads during Medicare Open Enrollment this fall.

We also took major steps to remove barriers to care created by prior authorization and utilization management in Medicare Advantage that are complementary to what my colleague, Stace Mandl, will be talking about. For 2024, we will keep up this momentum, maintaining our focus through our policy and operations on lowering drug costs, transforming care, and improving Medicare Advantage. We envision that Americans should receive care that is high quality, equitable, coordinated, affordable, and able to meet their unique needs. And they should be able to trust that the Medicare program will remain solvent for future generations. However, all of this work that I've been talking about is only possible through partnership with you. We appreciate your getting the word out, from the new benefits that are available for people with Medicare to the new opportunities for clinicians to participate and receive payment for the needed care that they provide to the people that we all serve together. So thank you for joining us today. And I'll now turn it over to Dr. Ellen Montz.

Dr. Ellen Montz: Thank you, Meena. And good afternoon, everyone. I am very happy to be here with you all this afternoon. I am Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO). On the Marketplace side of things this year, we had quite a year in 2023. Last year, we executed new programs and planned for

future enhancements for individuals and families transitioning out of Medicaid coverage, we worked against all odds to ensure that folks were and are protected from surprise medical bills and able to take greater control over their medical spending; we fortified our competitive markets; we raised the bar by installing new essential consumer protections in not only the Marketplaces but in the entire commercial market along with our colleagues at the Department of Labor and Treasury; and flexed our foundational muscles as we ramped up enforcements, modified systems, and made it easier for consumers to enroll and select the right coverage for them across our Marketplaces, and so much more. I would be remiss if I did not note we achieved these successes because we work together across CMS and that we work with you, our stakeholders, to leverage the best for our consumers.

All of this work, as the Administrator mentioned earlier, has contributed to the most successful Open Enrollment on the Marketplace in its history. Last time we chatted, I believe that I mentioned that I anticipated that this year's Marketplace Open Enrollment would be record breaking, and therefore, I am not surprised but am incredibly excited that we reached the new heights of over 20 million people selecting an Affordable Care Act Health Insurance Marketplace plan since Open Enrollment launched on November 31. Every plan selection means that someone is able to access coverage, someone is able to access care, and is therefore, able to access the life that they want to lead. And I could not be more thankful for all the work that you all do in helping make the Marketplaces a success for the millions of folks across the country. What a way to start the new year. And certainly a capstone achievement for all of us for 2023.

Looking ahead to this year, our work remains centered in the same focus areas that I think I come to you quarterly to talk about. Our CCIIO priorities really fall into three main categories as we look to 2024. First as always, increasing coverage. We will not rest until we get everyone out there who is eligible, but not enrolled, for the quality Marketplace coverage that we are offering. In addition to increasing coverage this way, we are highly focused on improving transitions in coverage between programs, particularly Medicaid to Marketplace, and also Marketplace to Medicare transitions--ensuring that folks have the most seamless experience as possible, so their lives aren't disrupted when they need to change health insurance programs. Second, increasing value. This includes pushing our markets and our insurers to deliver more, increasing access to services, and increasing consumer protections. This year, we will be particularly focused on ensuring provider access requirements in our regulations are actually providing the intended access to health care services for our enrollees; driving quality outcomes from our agent and broker-assisted enrollments on HealthCare.gov; and finalizing important consumer protection rules, including mental health parity and our short-term limited duration proposed rules that are currently out there.

And third, we're focusing on ensuring that we continue to fulfill the promises of the laws we implement. This includes ensuring that all of our programs are delivered with integrity and that we are using our enforcement powers to the fullest extent. And finally, that we are delivering on our ambitious rulemaking calendar. In all of our work, our true North Star is the consumer, and ensuring that we are providing accessible quality health care with equity at the forefront. We continue to work with you all, our stakeholders, to ensure the voice of our consumer is present in everything that we do. Thank you. And now, I will pass the mic over to my colleague, Sara Vitolo, who is the Deputy Director at the Center for Medicaid & CHIP Services.

Sara Vitolo: Thanks, Ellen, and welcome everybody. As Ellen said, I'm Sara Vitolo, Deputy Director for the Center for Medicaid and CHIP Services. I'm going to step through some of our 2023 accomplishments and focus areas for 2024. First up, we have Medicaid renewals. CMS is committed to ensuring that every American has health care coverage. Our top priority is to keep people covered in plans for which they are eligible. During the COVID-19 pandemic, Congress required states to keep people enrolled in Medicaid at a critical time—an unprecedented global health crisis. Now, states are starting to renew people's Medicaid coverage once again. We're working with states, providers, hospitals, and consumer groups to make sure people have coverage. We are pulling out all the stops to ensure people get the support they need to stay covered. At the federal level, we're actively monitoring and engaging with every state. States should take the full 12 months, give people ample time to respond, and take up more of the many federal flexibilities we've created to keep people covered. Health plans, providers, community-based organizations, schools, faith leaders, and anyone else who can engage people in their community need to do so. We're committed across the federal government to keeping people covered in whatever coverage is the right coverage for them.

Over the last couple of years, we've been focused on streamlining eligibility and enrollment as well. In August 2022, CMS proposed a new rule that would make it easier for millions of people to enroll in and retain their Medicaid coverage. The rule would reduce red tape and simplify applications, verifications, enrollment, and renewals for health care coverage throughout Medicaid and CHIP. CMS remains committed to this rule in 2024.

We've also been focusing on Medicaid and CHIP managed care--specifically, access, financing and quality. In April 2023, CMS proposed a new rule aimed at helping states build stronger programs to better meet the needs of Medicaid and CHIP populations by improving access and quality of care provided to Medicaid and CHIP Managed Care enrollees. This rule built on Medicaid's already strong foundation as an essential program for millions of families and individuals, especially children, pregnant people, older adults, and people with disabilities. CMS remains committed to this rule in 2024.

We're also focused on ensuring access to Medicaid services. In April 2023, CMS proposed a new rule that includes both proposed changes to current requirements and newly proposed requirements that will advance CMS's efforts to improve access to care, quality, and health outcomes, and better promote health equity for Medicaid beneficiaries across fee-for-service and managed care delivery systems, including for home and community-based services. These proposed requirements are intended to increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid programs. CMS remains committed to this rule in 2024 as well.

We're also focused on updates under the Medicaid Drug Rebate Program (MDRP). In May 2023, CMS proposed a rule that seeks to advance policies to promote efficient operations of the Medicaid Drug Rebate Program. The proposed rule seeks to enhance the Medicaid Drug Rebate Program integrity and improve program administration by proposing new policies that would assure greater consistency and accuracy of drug information reporting, strengthen data collection, and efficient operation of the MDRP. Again, we're committed to this rule in 2024.

And finally, we're focused on addressing challenges related to what we call the Four Walls policy. In 2023, CMS issued an informational bulletin announcing the further extension of the Four Walls grace period for Indian Health Services (IHS) and Tribal Facilities to February 2025. CMS remains committed to improving the health care of all American Indians and Alaska Natives. Thank you for your support. Now, I'll turn things over to Dr. Dora Hughes.

Dr. Dora Hughes: Thank you, Sara, and good afternoon. I'm Dr. Dora Hughes, Acting CMS Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality (CCSQ). 2023 was very productive for CCSQ, and we have a lot of accomplishments to share, but given our time limitations today, I'm just going to cover a few highlights. First, I will mention that our center developed and proposed the Long-Term Care Staffing Minimums rule on which we solicited comment in the fall of last year. The team received more than 46,000 comments on the proposal, which are being used to inform development of the final rule, which we intend to finalize this year. On the quality side, our center proposed and finalized several key pieces of policy in our Fiscal and Calendar Year Payment Rules. This included new measures to support equity, patient safety, best outcomes, patient-centered care and digital transformation. In addition, the rules continue to advance our work to align measures across programs using the Universal Foundation and the CMS National Quality Strategy as the framework. Of note, in the Physician Fee Schedule, building upon comments from several of my colleagues, we continued to expand access to mental health services, including for patients living in rural communities. For example, we finalized changes to the Conditions for Certification/Conditions for Coverage for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), as well as changes to the Conditions of Participation for Hospice, to include requirements allowing Marriage and Family Therapists and Mental Health Counselors to provide services in these facilities in an effort to expand access to behavioral health care.

We also finalized changes to the definition of Nurse Practitioners, making it consistent with current clinical standards and removing the requirement that Nurse Practitioners in RHCs and FQHCs be certified in primary care, thereby increasing the numbers of Nurse Practitioners that will be eligible to provide care in these facilities. Last year, CCSQ also worked to expand coverage through the Annual Wellness Visit (AWV) to include a Social Determinants of Health (SDOH) Risk Assessment, administered by way of a standardized, evidence-based SDOH risk assessment tool. This assessment will be optional, separately payable and require no beneficiary coinsurance nor deductible when furnished as part of an Annual Wellness Visit. Also, regarding coverage, last summer, we proposed a new Medicare coverage pathway--the Transitional Coverage for Emerging Technologies, also known as TCET. The TCET pathway uses current national coverage determination and coverage with evidence development processes to expedite Medicare coverage for certain Breakthrough Devices. In addition to the proposed TCET notice, we issued an updated proposed Coverage with Evidence Development guidance document and a proposed Evidence Review guidance document. We expect that these documents will offer insight into how CMS reviews clinical evidence and provides transparency regarding Coverage with Evidence Development. We are working to review the comments received across all of these guidances and will respond to them when we finalize the documents later this year. And as a final mention from our Coverage and Analysis Group, last summer when broader Medicare coverage became available for Leqembi for individuals with Alzheimer's disease, our team

developed and successfully launched a registry on the Quality Net portal to gather data that will help us understand how the drug works as well as any safety concerns.

Moving over to our Survey and Certification team here at CCSQ, our team worked on approximately 10,000 enforcement actions nationwide in 2023, helping to ensure the health and safety of patients and residents in health and long-term care facilities across the nation. I'm going to end with some great COVID vaccination stats, as our initiatives to reach nursing homes have been very successful. Last year, through continued vaccination efforts by our Quality Improvement Organizations, more than 1,200 vaccination clinics occurred, over 21,000 residents and over 6,000 staff were vaccinated.

In 2024, we remain laser-focused on improving safety, quality, equity and coverage across the care continuum. And with that, I'm going to turn it over to Dr. Liz Fowler, Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation.

Dr. Elizabeth Fowler: Thanks, Dr. Hughes and Administrator Brooks-LaSure. Thanks also to all of you for taking time to be with us today. Lots of exciting updates and highlights to share from the CMS Innovation Center, as 2023 was a busy year for us. We continued to work on embedding health equity in all aspects of our models and promoted transparency by releasing data on our models for researchers. We announced four new models: the Making Care Primary Model, the GUIDE (Guiding an Improved Dementia Experience) Model focused on dementia, the AHEAD (Advancing All-Payer Health Equity Approaches and Development) Model, the Total Cost of Care (TCOC) Model, and on December 15, we announced our fourth model of 2023, the Transforming Maternal Health Model, or TMaH for short. The TMaH Model focuses on improving health outcomes for mothers and their infants enrolled in Medicaid and CHIP, and reducing maternal and infant death health disparities, including disparities in severe maternal morbidity and low birthweight infants. This 10-year model will support participating state Medicaid agencies in developing a whole-person approach to pregnancy, childbirth, and postpartum care by addressing not only physical health, but also emotional and mental wellbeing. For example, as part of this effort, mothers and babies will receive support for certain health-related social needs through connections to community-based organizations that may provide virtual group parenting classes, or nutrition and food supports. State Medicaid agencies participating in this model will focus on three objectives: improving the safety and quality of care, delivering whole-person care, and growing the workforce capacity and infrastructure with the aim of ultimately increasing access to care. So keep an eye out for the Notice of Funding Opportunity for state Medicaid agencies coming later this spring.

At the end of last week, we announced our first new model of 2024--the Innovation and Behavioral Health Model, or IBH for short. CMS is dedicated to addressing our nation’s behavioral health crisis, and the IBH Model reflects this commitment. IBH is a state-based model focused on providing integrated, whole-person care to Medicare and Medicaid patients with moderate to severe mental health conditions and/or substance use disorder. Behavioral health practices participating in IBH will be responsible for coordinating care across different types of providers to support a patient's behavioral and physical health as well as any health-related social needs. Through aligned Medicare and Medicaid payment for these integrated services, the model seeks to bridge the current gap between mental and physical health by connecting patients with

the behavioral, physical and social supports needed to manage their care. As with the TMaH model, we anticipate releasing a Notice of Funding Opportunity later this spring.

Looking forward, we have other new models in the pipeline and expect to make additional announcements in the coming weeks. We'll also be continuing to launch the models that we announced in 2023. For example, we anticipate announcing the new model participants in the Making Care Primary Model in time for a July 1 start date. And the application period for the new GUIDE dementia model closes soon, so there's still time for organizations to apply, and additional time for states to apply to participate in the AHEAD Model. Thanks for all of your interest in our work. We believe these models and our initiatives can improve care and the care experience for Medicare and Medicaid patients across the country. I'll stop there. Thanks again for being here and stay tuned for more information on these models and other exciting work we're doing in 2024. And with that, I'm going to turn it over to my colleague, Dara Corrigan.

Dara Corrigan: Hello, good afternoon. And thank you, Liz for your introduction. I am Dara Corrigan, Director of the Center for Program Integrity, also known as CPI. And today, I am very happy to share with you some of our fourth quarter accomplishments in 2023, and some of the areas that we'll be focusing on in 2024. As you probably know, CPI's mission is to prevent and address fraud, waste and abuse in Medicare, Medicaid and the Marketplace. We view ourselves as the catalyst for stopping bad actors so that we can safeguard access to care for everyone who is enrolled in our programs. Every year, we strive to save the government money and we measure, in part, how successful we are by the amount of money that we saved. Looking back, in 2022, we saved $4.1 billion, and preliminary savings for Fiscal Year 2023 totaled $4.4 billion in Medicare and Medicaid. In addition to our financial savings, there are four areas of program success that I'd like to highlight from 2023. First, last January, we finalized a regulation which allows us to, for the first time in over a decade, collect overpayments made to Medicare Advantage organizations, similar to what we do in traditional Medicare or Medicare fee-for-service. This is an important step forward because it lays the groundwork for CPI to ensure integrity over a significant part of the Medicare program that has gone without meaningful oversight for too long. And new audits will begin this year. Second, as part of its oversight of the Marketplace, CMS took action against 24 agents and brokers suspected of fraudulent activity, canceled over 2,500 unauthorized enrollments, and we referred five agents and brokers to the Office of the Inspector General. Third, we worked very hard to protect against bad actors taking advantage of our programs and beneficiaries for their own financial gain by improperly billing for COVID-19 over-the-counter test kits. We implemented over 150 payment suspensions and referred potential bad actors to our law enforcement partners in the Office of the Inspector General and the Department of Justice. We prevented an estimated $1.4 billion in payments from going out the door through our work in this area in Fiscal Year 2023. Fourth, CPI issued final regulations requiring more disclosures about the ownership, management and control of Medicare skilled nursing facilities and Medicaid nursing facilities. This includes ownership by private equity companies and real estate investment trusts. We will collect this data in 2024, which will lay the groundwork for evaluating whether these types of ownership lead to increased costs or lower quality of care. We're proud of these accomplishments, and we stand ready to build on them in 2024 using every tool and strategy available to find innovative and new solutions to protect the integrity of our programs and the individuals enrolled.

And before I close, I would like to highlight just two areas of critical importance for us in 2024. Number one, we will build on our 2023 program integrity strategy aimed at better addressing potentially fraudulent hospices on the front end, before they enroll or very closely after enrolling in the Medicare program. Our goal is to make sure that hospices are providing critical, quality, end-of-life care to our Medicare beneficiaries. And number two, we will continue to enhance our use of artificial intelligence, including machine learning and other techniques to detect atypical billing patterns within claims data and other data sources. At the same time, we are very aware of and will continue to investigate potential negative uses of artificial intelligence by bad actors. For example, bad actors may use artificial intelligence to manipulate medical records to support fraudulent government billing. We're committed to using trustworthy and responsible artificial intelligence best practices to ensure ethical application of this technology to enhance our work.

We look forward to more engagement with you across CMS in 2024 and to really focusing on how we can better serve individuals enrolled in our programs and preventing bad actors from using our programs for their own ends. And now I'd like to turn it over to Dr. Aditi Mallick. Thank you.

Dr. Aditi Mallick: Thank you, Dara, and hello everyone. My name is Dr. Aditi Mallick, and I'm the Acting Director of the CMS Office of Minority Health, also known as OMH. As we start 2024, our OMH team is focused on sustaining the momentum that we've built to really ensure that equity remains a part of each decision that CMS makes. And we had a remarkable 2023, largely thanks to your partnership. This past June, we hosted the inaugural CMS Health Equity Conference with over 5,500 in-person and virtual attendees at Howard University in Washington, DC. We heard about the importance of acknowledging historical and persistent injustice, addressing social drivers of health, and partnering with diverse communities and organizations to address disparities in our health care system. That conference really was a success because of you. Please save the date for this year's hybrid conference, May 29 and 30, at the Hyatt Regency in Bethesda. And if you have work to highlight, I strongly encourage you to submit a proposal. The deadline for abstracts is February 9, and we would love to hear from you. You can find more information about the conference at cmshealthequityconference.com.

We also deepened our partnerships in the last year by hosting a number of roundtables and listening sessions that informed the agency's work on Sickle Cell Disease and improving health care access in the Pacific and Caribbean U.S. Territories; and by visiting rural and tribal communities across the country to share consumer-friendly resources to help individuals make the most of their health care coverage. 2023 also marked a year we took action to address long-standing disparities in chronic diseases. We announced the CMS Diabetes Strategy and the CMS Sickle Cell Disease Action Plan, and we intend to build on those efforts in 2024. To complement our listening, we recognize the importance of data, research, and analysis to identify disparities and inform policy making. Last year, we released reports highlighting differences in care among rural and urban communities, members of minority communities, and disparities affecting people with disabilities and those dually eligible for Medicaid and Medicare as well as those receiving Low-Income Subsidies (LIS).

Looking ahead, we anticipate more enhancements to our interactive Mapping Medicare Disparities tool, which can be used to identify disparities in claims, utilization, hospitalization,

social drivers of health and more. We'll also continue supporting research that examines critical health disparities through our Minority Research Grant Program and Health Equity Data Research Program, and through our release of our race and ethnicity imputed algorithm, or the MBISG (Medicare Bayesian Improved Surname Geocoding), to researchers. We also look forward to continuing our work with all of you through our Health Equity Technical Assistance Program that offers tools and resources to individuals and organizations to really build health equity into their work.

Over the years, we have responded to hundreds of questions from partners in nearly every state and territory of this great nation. And last year, we received many questions around social drivers of health from Quality Improvement Organizations, health plans, providers and health systems, and others. And in 2024, we're working on resources and tools to address your questions around social drivers of health and other areas. I hope that today's call really is just one of many conversations we will have this year as we continue in this work together. Thank you again for joining us today. And I'll now turn it over to my colleague, Stace Mandl, Acting Director for the CMS Office of Burden Reduction and Health Informatics (OBRHI). Stace, over to you.

Stace Mandl: Thank you, Dr. Mallick. We're proud to share that on January 17, CMS released the CMS Interoperability and Prior Authorization final rule. The final rule will reduce burden for patients, providers and payers by streamlining prior authorization processes and moving the industry toward electronic prior authorization. These changes will help patients access care in a timely manner and enable clinicians to spend more time focusing on direct patient care. This rule also demonstrates our continued commitment to ensuring that health information is readily available to the right person at the right place and at the right time. We are leveraging Application Programming Interfaces, or APIs, which is the technology that allows two different systems to talk with one another.

Several important policies are in this final rule, and they include faster prior authorizations. Impacted payers are required to send prior authorization decisions for standard requests within seven calendar days, and decisions for expedited requests within 72 hours, starting in 2026, which will significantly reduce wait times for providing care. If they deny requests, payers must provide specific reasons, making appeals easier. The rule also increases transparency by requiring payers to publicly report certain prior authorization metrics. A new prior authorization API will help automate the prior authorization process and include information such as which items and services are required for prior authorization and what documentation is needed to support the request, thereby saving time and creating a seamless process for payers, providers, and patients. The existing Patient Access API will be expanded to include prior authorization information, empowering patients with access to more of their data. And the new Provider Access API will enable patients to allow their providers easier access to their health data from payers, facilitating better care coordination and decision-making. Also with patient permission, payers will be able to securely exchange health data with another payer, allowing data to follow the patient if they change payers.

Finally, along with the release of the final rule, we announced that HHS (Health and Human Services) will exercise enforcement discretion for the use of the HIPAA (Health Insurance

Portability and Accountability Act) prior authorization transaction standard to provide flexibility for implementing electronic prior authorization and further promote efficiency in the process. This means that impacted payers can implement an all FHIR (Fast Healthcare Interoperability Resources) based API or use the X12 standard with the API if they choose to do so. We are excited to continue this work by exploring additional opportunities to streamline the prior authorization process, and we look forward to engaging with all of you on additional ways we can support the health care workforce and return time back to patient care. I will turn the call over to Eden who will move us through and into the Question & Answer session of today's call.

Eden Tesfaye: Many thanks to you, Stace, and to all of our speakers who joined us today to provide some insight into the things that we're super proud of from last year and continue to lead the charge on here at this agency. As I mentioned earlier, we solicited questions prior to the call, and we'll walk through those now. My first question is for our Medicaid Center's Deputy Director, Sara Vitolo. Is there a nationwide tracker for each state's impact on the Medicaid Unwinding, also known as Medicaid Renewals Process, for the COVID-19 Public Health Emergency?

Sara Vitolo: Absolutely, there is. The Medicaid and CHIP renewal data is posted on our website at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/data-reporting/monthly-data-reports/index.html. These reports show how states are resuming regular eligibility operations following the end of the Medicaid continuous enrollment condition authorized by the Families First Coronavirus Response Act. The Consolidated Appropriations Act, 2023 (CAA, 2023) requires state monthly reporting about activities related to eligibility renewals, call center operations and transitions to Marketplace coverage from April 1, 2023 through June 30, 2024. CMS is also providing information such as changes in Medicaid, CHIP, and Marketplace enrollment; state operational data; and additional renewal metrics. The monthly reports contain state-level Medicaid, CHIP, and Marketplace metrics. CMS will consolidate data from multiple data sources. Given differences in availability of data across data sources, CMS will release each month's data as part of multiple releases.

Eden Tesfaye: Thank you, Sara. Our next question is for Acting Director of the Office of Minority Health, Dr. Aditi Mallick. How can CMS stakeholders continue to advocate for and provide access to behavioral health resources—in particular, for those historically underrepresented communities?

Dr. Aditi Mallick: Thanks for the question, and thanks to whoever submitted that question. Addressing the behavioral health crisis continues to be a key priority for us here at CMS. Medicaid and CHIP, as you may know, are the largest national payers for behavioral health services, paying for more than a quarter of the country's behavioral health services. And we know that behavioral health conditions affect people of all ages. About one in five people over the age of 65 live with a mental health condition, including depression, anxiety, dementia, schizophrenia, and bipolar disorder. About 8 percent of people with Medicare younger than 65, and 2 percent of those 65 and older have a substance use disorder as well. So with that, we as an agency recently released a refresh or an update of the **CMS Behavioral Health Strategy**, and we'll ensure that you have a link to that in the chat. It covers multiple elements, including access

to prevention and treatment services for substance use disorders, mental health services, crisis intervention, and pain care, and further enables care to be well-coordinated and effectively integrated. The CMS Behavioral Health Strategy also seeks to remove barriers to care and services, and to adopt a data-informed approach to evaluate our behavioral health policies and programs. And with this strategy, we are striving to support a person's whole emotional and mental well-being and promote person-centered behavioral health care. You can get more information on the Behavioral Health Strategy at cms.gov, where we continue to share CMS behavioral health information and resources across the 3 Ms: Medicare, Medicaid and CHIP, and the Marketplaces. Thanks again.

Eden Tesfaye: Thank you so much, Dr. Mallick. Just a reminder for folks that we'll have a recording and transcript and summary of this call posted on our website in the next couple of weeks, if folks had any trouble hearing our speakers. And I think a link is going to be dropped into the chat. There it is.

Well, that wraps up our Question & Answer session of this call. Thank you again to all of our speakers today. And thanks to each and every one of you who took the time to join us. As you heard today, the people we serve across our programs have been, and will continue to be, the focal point for 2024, and the CMS team looks forward to the work we'll do together for them. Thanks again for your partnership and for joining us today. Please keep an eye out for the invitation to our next call, and I hope you have a wonderful rest of your Tuesday. Bye.