Centers for Medicare & Medicaid Services

Quarterly National Stakeholder Call with CMS Administrator

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Bruce Alexander: Hello, and welcome to all of the over 3,400 folks on the call right now. My name is Bruce Alexander, and I am the Director of the CMS Office of Communications. Thank you for joining us today for our first Centers for Medicare & Medicaid Services, National Stakeholders Call of 2023. I will walk you through today's agenda and turn things over to our speakers. Before I do that, I want to share a few housekeeping items. First, this call is being recorded. Also, while members of the press are welcome to attend the call, please note that all press or media questions should be submitted using our media inquiries form, which you can find at cms.gov/newsroom/media-inquiries. We will not be accepting live questions during the call today. However, we did solicit questions beforehand, and we will answer a few of those today.

Today's agenda is explained on the screen. We have a full agenda that includes our CMS Administrator, Chiquita Brooks-LaSure, and her leadership team providing an update on CMS' 2022 major accomplishments and looking ahead to how our 2023 priorities will advance the CMS strategic plan. These presentations will be followed by a question-and-answer session. And with that, I'll turn it over to our leader and Administrator, Chiquita Brooks-LaSure. Administrator?

Chiquita Brooks-LaSure: Thank you so much, Bruce. And thank you all for joining us today. I don't know about you, but it feels like January has started and has been incredibly busy for all of us. And I think that here at the agency, we've all been hitting the ground running. And I know you all have been as well.

I'm really excited to kick off the new year and just to talk a little bit about some of the things that we have been doing really in partnership with all of you. And as Bruce said, you'll hear from the entire leadership team about some of the things underway at the agency. So, I'm just going to spend a few minutes highlighting some of the things that are high on our list.

I'm going to start with health equity. I think just to say how energized we all remain in making sure that the programs operated by CMS continue to have an equity focus. And whether that means in the way that we look at our payment policy, whether we're talking about quality initiatives, whether we're thinking about the materials that are prepared for providers, health plans, and of course, people who are served by our programs. We're really excited about the work underway. In December, we had what was, I felt, like an incredibly meaningful discussion

and meeting among stakeholders to talk about maternal health, one of the starkest discrepancies in our country when it comes to racial inequities across women and birthing people. And we just had an incredible time and saw just so much participation, particularly from the private sector, as we unveiled our "Birthing-Friendly" Hospital designation and had many plans join us to really cover their private coverage as well. So that's just one of the highlights of the work that we're doing on health equity. But this is an all-agency approach, and of course, with all of you.

I also want to mention some of our real focus on things that will improve care for the lives of people. And particularly for the clinicians that are served. As you probably know, we put out three proposed rules that were really around inoperability, electronic adoption, and prior authorization. I and some of the other leaders were in a meeting with clinicians and really hearing what a difference making sure that the rules of the road will be for their delivery of care and for making sure that people get the care they need. And so, we look forward to your comments on those rules. And our goal is to ensure people have access to care.

Similarly, we're excited about implementing the No Surprises Act and the ability for consumers to be protected from unexpected, surprise bills, usually at the point of real acute need in their lives. Whether through surgeries or other instances. And so, the agency continues to focus on that.

As we think about our incredible programs, which now cover so many people, over 150 million people in this country, we're excited about the new authority we've been given. Certainly, Dr. Seshamani will talk in more detail about our implementation of the Inflation Reduction Act, which makes a difference in the lives of millions of people today. ASPE outlined in a new study just what a difference it makes in the lives of millions of people to have their insulin capped. And I hope that from a stakeholder perspective, our laying out the rules of the road for Medicare negotiation is helpful.

So, I could go on and on about the great work of this agency, but I'll end with just our excitement, as I said, over 150 million people that are covered. And that is largely due to the incredible work of everyone on this team. We're at the end of our exciting healthcare.gov Open Enrollment period. Some states go through the end of the month. But after a record year last year, we're now having another record year. And it's amazing just how far we've come since the passage of the ACA. And now, with the Inflation Reduction Act, and additional efforts by the Biden-Harris Administration, we're seeing millions of people able to see their coverage much more affordable. So, with that, I will turn the mic over to Jon Blum, whom you all know so well, our Principal Deputy Administrator and COO. Jon?

Jon Blum: Great, thank you so much, Chiquita. I want to talk about how we're operating in 2023, but more importantly, how we're thinking about 2023. And as folks probably know, during 2022, our team built what we think is the most far-reaching plan for CMS ever. That plan was founded with six guiding principles. And each CMS center and office has built their own plan that ties to those six pillars.

We have thirteen cross-cutting projects. They're designed to think about how we change healthcare, delivery, and CMS operations to focus on one center, to one office, and to have a

whole CMS approach. And we know that Medicare, Medicaid, Marketplace don't just serve CMS beneficiaries, but they change through time. And what you will see from CMS going forward is a much stronger tie-in, much stronger work, focus, for not just how our separate programs work but how each focus area really ties together. So, we give beneficiaries more and more one-customer experience and a much better connection to CMS and to their healthcare system.

So, as we set the plan out for 2022, we set out 400 metrics that we watched and tracked to guide progress that you will hear more about today. And as we think about 2023, we're going to be setting, using the same plan, but setting even more ambitious metrics for us to tie the programs towards and to ensure that we continue to show progress and deliver really key results to our customers.

As we think about CMS programs going forward, we are going to be hyper-focused on not just integrating the programs but really integrating policy operations and communications. So, we know that when those three pieces are tied together that we get a better experience and we get better results. And that we serve you much, much better. So, whether it's drug negotiation or signing up for coverage, those three pieces will have much more integration going forward to give you, to give CMS customers that one uniform experience.

We are contracting more than ever before. During 2022, CMS signed contracts that totaled more than $7 billion. That's not just for one year but for the contract life cycle. As CMS thinks about contracting going forward, we'll be stressing two or three things. Number one is fiscal stewardship. And we know that when we push to get the best value for our contracts, it lowers cost and produces better value for the taxpayers and results. So that's an area in the contract with CMS going forward that will see even more fiscal stewardship going forward.

Second, we are shifting more and more of our claims processing systems to the cloud. It's safer and more secure, but it's also lower costs. So those who are building CMS systems should know that's going to be the continued focus going forward. And tied to that second point, the third point that CMS will be stressing is that we must do everything we can to keep data secure to honor privacy for our CMS consumers. So that will be stressed even more going forward to ensure that we're doing everything possible to keep our systems and collective systems as secure as possible.

The last point I want to make is that CMS is hiring. During 2022, CMS permanently hired 500 positions. Right now, we have job openings and job placements for more than 700 people throughout the agency. That's roughly 10% of the total CMS workforce. So, as we continue to build programs, continue to contract better, to continue to deliver great results, we are also going to be hiring. So those folks on the phone that are thinking about federal service, hopefully thinking about CMS service, check out CMS job postings. We are building the CMS workforce for the future. I hope that you consider joining us during 2023. With that, I will stop and turn the floor over to my colleague Meena Seshamani. The floor is yours.

Dr. Meena Seshamani: Thank you, Jon. And it's good to be here with you today. I'm Dr. Meena Seshamani, the CMS Deputy Administrator and Director of the Center for Medicare. My team

has had an extraordinary year. And I'm proud to be working alongside them and all of you to improve the program for the 64 million people who rely on it to stay healthy and well. I would like to highlight our work around the Inflation Reduction Act, value-based care, and Medicare Advantage. As the Administrator mentioned, we hit the ground running by implementing the Inflation Reduction Act. And we're really excited about some of the new benefits that people with Medicare now have. For example, as of January 1st, someone with Medicare who takes insulin covered by their prescription drug plan will not pay more than $35 a month for a month's supply of each covered insulin product. People with Medicare drug coverage will pay nothing out of pocket for recommended adult vaccines.

We also recently proposed changes to implement a key provision of the Inflation Reduction Act to make prescription drugs more affordable for approximately 300,000 low-income individuals. And we recently released a timeline that sets the stage for multiple comment opportunities for the Medicare Drug Price Negotiation Program for members of the public. This is one of the ways in which we are prioritizing transparency and robust engagement. We know that this feedback can help us strike the right balance between improving drug affordability and access while also providing the right incentive to continue innovating new therapies. So, we thank you for your feedback, insight, and ideas in the dozens of meetings we have had already. And we look forward to an ongoing discussion.

Now moving to value-based care. To build on something we've discussed before, more than 13.2 million people with Medicare and more than 700,000 providers and organizations are participating in our Accountable Care Organization programs (ACO). We're expecting even more growth in the coming years. The policies we announced in the fall of 2022 are the first set of enhancements in growing the Medicare Shared Savings Program (MSSP) and represent some of the most significant reforms since the program's inception. For example, building on the CMS Innovation Center's successful ACO Investment Model, CMS is incorporating advanced shared saving payments to certain Medicare Shared Savings ACOs that can be used to address Medicare beneficiary's social needs--one of the first times that traditional Medicare payments would be permitted for such use.

Going forward, we are first working to implement these finalized policies this year. But we are also considering changes that would increase participation in these programs, advance health equity, and increase alignment. This includes working with The Innovation Center to test new models on the MSSP chassis and how to best incorporate primary care providers and specialists in ACOs. We're also thinking about how we can address some of the barriers that ACOs have been experiencing with quality reporting while moving towards our goal of greater alignment of quality measures. We're continuing to think about what is working with the CMMI model test that we should consider incorporating into the Medicare Shared Savings Program.

Now moving to Medicare Advantage (MA). Medicare Advantage is an important part of the overall Medicare program. As you may recall, in July, we issued an unprecedented Medicare Advantage Request for Information asking for feedback to improve the program across a number of key areas. We were thrilled to receive roughly 4,000 comments from a wide range of stakeholders, and in fact, the policies and the recently-announced Medicare Advantage and Part D proposed rule for 2024 were informed by that feedback. So, we thank you for your thoughtful

input and suggestions. If finalized, the policies in this proposed rule would strengthen the Medicare Advantage program for more than 29 million people who rely on it for health coverage and will enhance the Medicare Part D program for 49 million people in the program. The proposed rule takes important steps to protect beneficiaries and enhance MA and Part D benefits. And it provides additional guidance to help CMS effectively collaborate with health plans and others to best meet the needs of people enrolled in MA.

Collectively, these three initiatives that I've discussed today-- implementation of the Inflation Reduction Act, our work with value-based care, and our work with Medicare Advantage-- advance CMS's goals to advance health equity, expand access to coverage and care, drive innovation, and protect our program's sustainability. Clearly, we cannot do all this work without your ongoing partnership and feedback. So thank you so much for all you're doing for people with Medicare. I'll now turn it over to Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight.

Dr. Ellen Montz: Thanks, and good afternoon, everyone. It is fantastic to be here with you today. I'm excited to share our accomplishments over the past year. And really turning to this year where we are focused. First, as the Administrator mentioned, I want to celebrate how successful and smooth this year's Marketplace Open Enrollment was. And of note, we have a few states that are still open. So those of you in those state-based Marketplace states still signing people up, thank you, keep going.

We are still tallying the final numbers. But as we announced a couple of weeks ago, and it remains true, we know that we've already surpassed last year's enrollment totals. And we know these numbers are the direct result of this year's winning combination of record affordability, robust plan options, improved consumer experience, and large-scale outreach and enrollment assistance. Our 10th Open Enrollment anniversary and the best one yet. I cannot express enough gratitude to all of you for your support in making this happen. We will have an important announcement on numbers from both the federal and state-based Marketplaces tomorrow. So, stay tuned.

Looking forward to this year, I want to highlight a couple of items. First, the thing that is top of mind for many of you is also top of mind for CCIIO and the Marketplaces. And that's the end of the continuous coverage requirement under Medicaid, which was part of the Consolidated Appropriations Act (CAA) signed by the President last year. What I want to emphasize today, and I'm sure Dan will talk about more, is that over the past year, CMS, states, state-based Marketplaces, departments of insurance, you name it, have developed and been in the process of developing robust plans for mitigating coverage loss wherever possible by ensuring that individuals who remain eligible for Medicaid and CHIP stay in Medicaid and CHIP. And individuals who are no longer eligible transition to the affordable Marketplace coverage we provide or employer-sponsored coverage if eligible.

At CCIIO, we have been laser-focused on successfully transitioning those no longer eligible for Medicaid and CHIP to the Marketplace where appropriate. We have implemented system changes and policies to make it easier to enroll in coverage. We have bolstered assistance networks with more funding for navigators as well as specific trainings aimed at assisters, agents,

and brokers. We have harnessed the power of partnerships across the Federal Government, Medicaid, State-based Marketplaces, Insurance Commissioners, and groups like you. We have planned aggressive Open Enrollment style outreach campaigns, and importantly, we have record affordability on the Marketplace thanks to the Inflation Reduction Act. All of which did not exist the last time Medicaid agencies performed redeterminations. And the Marketplaces have a long record of successfully connecting consumers to coverage. And this bears out in the numbers I mentioned. But as many of you know, these coverage transitions from Medicaid and CHIP to the Marketplace are not seamless, and we need your help. Your partnership in connecting individuals to coverage is critical. Much more to come from us here. We will be publishing additional Marketplace guidance on unwinding soon. But in the meantime, visit Medicaid.gov\unwinding for the latest.

The other timely area of focus I want to mention is our continuous work to increase insurance's value and drive better health outcomes and health equity through Marketplace plans. We do much of this work through our annual payment notice. Our 2024 Notice of Benefit and Payment Parameters (NBPP) or 2024 Payment Notice Proposed rule was released in December. The comment period, I believe, closes this coming Monday. So please get your comments in. We greatly appreciate your feedback. This proposed rule includes standards for issuers on the Marketplaces and requirements for agents and brokers, web brokers, and assisters. If finalized, these changes would build on the Affordable Care Act's promise to expand affordable access with a specific focus on mental and behavioral healthcare services, simplifying choice and improving plan processes for consumers, making it easier to enroll, strengthening markets, and bolstering Program Integrity.

We look forward to your comments. Thank you again for your partnership as we close out this wildly successful Open Enrollment and look forward to new opportunities in 2023. With that, I will turn it over to Dan Tsai, Deputy Administrator and Director for the Center for Medicaid and CHIP Services.

Dan Tsai: Thanks, Ellen. As Ellen noted, beginning Medicaid redeterminations and connecting and helping folks maintain coverage is the one, two, three, four, five, six, seven, eight, nine, and ten priority at the moment. But let me take a moment to highlight some things from the past year and what we're looking forward to in the coming year, and thank you for your continued engagement with us.

Our themes for Medicaid and CHIP have been coverage and access, health equity, innovation, and whole-person care. And that has driven a lot of the work we have done in partnership with states and putting out proposed rulemaking. So things like our proposed rule on streamlining Medicaid and CHIP eligibility and enrollment move us forward for all populations of Medicaid and CHIP. Things like approving continuous eligibility for kids from 0-6 years old or in Massachusetts for 24 months for homeless individuals. Those are really important pieces that help advance that framework of coverage. We now have 28 states that have taken up the 12-month postpartum coverage piece of Medicaid, which is really, really important from a health equity standpoint, as you heard from the Administrator. And we are very excited that the Omnibus has made that permanent.

So, along the themes of equity and innovation, whole-person care from the past year, we spent some really intense time with our state partners making groundbreaking Section 1115 Demonstration Approvals and Managed Care Approvals, really thinking about the role of health-related social needs and social determinants of health in the Medicaid program. Specifically, coverage within certain bounds of housing and nutritional supports and linking those also to commitments from states in raising base rates for things like primary care, behavioral health, and OB/GYN services. Those are all really fundamental underpinnings of the program. And we're really excited to have them partnering deeply with states on that, as well as a substantial amount of work that will continue this work on behavioral health, home, community-based services, kids, school-based Medicaid, et cetera.

A huge portion of the past year has been preparing for all the work for resuming Medicaid renewals and redeterminations as we look toward the coming year. And as you heard from Ellen, it has been a whole of government across the CMS approach. We have been in the trenches with state partners—hundreds of pages of guidance. And states will be resuming this spring. And Medicaid redeterminations. And we are engaged with folks on that.

Our first priority is to ensure we are helping folks maintain coverage through Medicaid if they remain eligible, or we help folks transition to the Marketplace and other forms of coverage. So much more we will talk about there, but that is a top priority for us as an administration. And we are, I would say, daily in the thick of it with our state partners helping to push things forward. And as we look forward to '23, I think you'll see us putting substantial pieces into the market around really lifting the floor for Medicaid in terms of access and how we think of managed care. We've received much stakeholder engagement and comments, and we appreciate them, and it will be a very interesting year ahead. We are focused on helping folks maintain coverage. And then we want to strengthen the bar and the floor on access and many other important pieces for thinking about health and outcomes for our population.

So with that, I will turn it over to my colleague Jean Moody-Williams, the Deputy Director at the Center for Clinical Standards and Quality at CMS.

Jean Moody-Williams: Thank you so much, Dan. And thank you all for joining this call today. We remain focused on our goals of creating a more equitable, safe, and high-quality, outcomes-based healthcare system rooted in the principles of the CMS Quality Strategy. In November, we participated in the Department of Health and Human Services Patient Safety convening. We are committed over the next year to using all policy levers, including our Quality Improvement Organization support, and improved and expanded quality measures, increased transparency, and a strong payment incentive to promote improved safety outcomes. Patient and caregiver engagement is essential in developing long-lasting and meaningful safety improvements. We are listening to these voices and encouraging healthcare systems to include patients and error reporting, communications and resolution processes, and the patient's family advisory councils.

We have heard the concerns about worker safety. CMS issued a Workplace Violence Memo reiterating to hospitals that we will continue enforcing the regulatory expectations to ensure patients and staff remain safe. As Administrator Brooks-LaSure mentioned in February of 2022, the President announced reform aimed at improving the safety and quality of care in nursing

homes. CMS conducted a study to assess the minimum staffing requirements needed to ensure residents receive safe and quality care. The staffing study consists of a literature review, nursing home site visits, quantitative analysis, and cost analysis. The report includes recommendations of potential barriers to and unintended consequences of implementing the recommendations and cost implications. We are currently reviewing it to determine our policy direction.

As part of the administration's priority to improve the safety and quality of care in nursing homes, CMS revised the Special Focus Facility(SFF) program to protect and improve residents' quality of care. We also announced plans to take a new step to increase the transparency of nursing home information by publicly displaying survey citations that facilities are disputing. Currently, when a facility disputes a deficiency, that deficiency is not posted to Care Compare until the dispute process is complete. And that may take a while. But this new process will improve transparency and make the preliminary information available sooner.

Beginning this month, CMS will conduct targeted off-site audits to determine whether nursing homes accurately assess and code individuals with a schizophrenia diagnosis. Nursing home residents who are erroneously diagnosed with schizophrenia are at risk of receiving poor care and being inappropriately prescribed antipsychotic medication. The Administrator mentioned our new publicly reported “Birthing-Friendly” Hospital designation on Care Compare. And we're all excited about this. This designation will focus on maternity care so consumers can more easily identify hospitals that provide high-quality maternity care. One of the pillars of the CMS strategy is engaging partners. We've held several listening sessions over the past year, including topics on Emergency Preparedness and Culturally Competent Person-Centered requirements. This information is invaluable as we progress in policymaking in the coming year.

Finally, our work to protect the health and safety of patients, residents, and staff from COVID-19 continues. We have been working with Quality Improvement Organizations to submit best practices and ideas for increasing COVID-19 vaccine uptake. Those ideas were shared widely along with podcasts recorded with the FDA and the CDC. Which not only offered vaccine information but information on therapeutics and the facts surrounding that. So, we've had an exciting year. And we look forward to the year to come.

I'm now going to turn it over to Dr. Elizabeth Fowler, CMS Deputy Administrator and the Director of the Center for Medicare and Medicaid Innovation. Liz?

Dr. Elizabeth Fowler: Thank you so much, Jean, and thank you all for taking the time to be with us today. I'm really proud of how much the Innovation Center accomplished in 2022. In alignment with the CMS strategic vision and priority, the Innovation Center set a bold vision, building toward a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. In November, the Center published a one-year strategy update detailing our progress toward implementing the strategy over the last year. Starting with driving accountable care, the Center advanced the goal of having 100% of beneficiaries in an accountable care relationship by 2030. This was accomplished through scaling successful features of the ACO Investment Model in the Medicare Shared Savings Program, redesigning the ACO REACH Model, announcing the new Enhancing Oncology Model, and advancing our

vision and strategy to integrate specialty care. I'm also pleased to have Dr. Seshamani and her team as partners in this journey.

We also made significant strides in advancing health equity by requiring participants to submit health equity plans and new models, testing innovative payments for providers caring for underserved populations, and designing approaches for screening and referral to address social needs. In supporting innovation, we know value-based care is successful when patients receive care that reflects their preferences and goals. Last year we took steps to support innovation by announcing our strategy to increase patient-reported outcome measures(PROMs) used in our models and requiring the collection of self-reported demographic data in new and redesigned models to inform innovations that support comprehensive person-centered care.

Keeping the impact on people in mind, the Innovation Center made progress in addressing affordability through testing the coverage of Part D insulin at $35 or less per month, which served as a model for the provision included in the Inflation Reduction Act, which Dr. Meena Seshamani mentioned earlier. One of the accomplishments is our partnership with all of you to achieve system transformation. Last year, we held ten beneficiary engagement sessions and 1200 attendees at the LAN Fall Summit, produced new consumer-friendly language to build an understanding of our work, and disseminated the refresh to over 10,000 individuals through blogs and papers. Looking forward, 2023 is shaping up to be an exciting year. We continue to be laser-focused on the future to realign healthcare delivery to keep the focus on patient health and the best care possible.

As the one-year update outlines, in 2023, we aim to announce three to four new models on advanced primary care, population and condition-specific accountable care models, and a state total cost of care model. Where possible, these models will include a focus on underserved populations and making it possible for more safety net providers to participate. We'll continue to focus our strategies on driving the integration of primary and specialty care to serve those with chronic or severe conditions through our models.

I'll stop there. Thank you again for being here. And stay tuned for more information on new models to be announced in 2023. With that, I will turn it over to George Mills, Deputy Director of the Center for Program Integrity, to talk about their highlights from the last year and upcoming priorities.

George Mills: Thank you, Liz. Everybody, again, my name is George Mills. I'm the Deputy Director of the Center for Program Integrity (CPI) here at CMS. Today I am highlighting some of CPI's accomplishments from last year and touching on some of CPI's focus areas and priorities for the upcoming year.

In 2022, we did a project related to advancing health equity. Our mission includes protecting our beneficiaries. And one way we do this is by removing fraudulent providers from the Medicare program via a process known as the revocation process. We don't want our beneficiaries receiving care from bad actors. However, CPI was equally committed to advancing health equity by weighing the impact of our actions on rural areas and underserved communities. Therefore in 2022, CPI worked with our colleagues in the Center for Clinical Standards and Quality (CCSQ),

the Office of Burden Reduction and Health Informatics (OBRHI), and the Office of Minority Health (OMH) on a study to look at the impact on individuals who live in underserved communities and providers who may experience increased patient burden when a fraudulent provider is moved from the Medicare program in their area. What we found is that patients exposed to revoked or fraudulent providers tend to be disproportionately underserved, non-white, and then disabled, and elderly. And in many cases, a dual eligible.

Based on the findings, which looked at metrics, there's no clear evidence that revocation actions had unintended consequences or increased burden on patients or clinicians due to our revocation action. However, we'll continue to study and follow up on work to inform our work in the future.

We believe that the integrity of the Medicare and Medicaid programs is best supported through program transparency. In April of '22 , CPI publicly released data related to the ownership and management of hospitals and nursing homes in Medicare for the first time. In September of '22, CPI expanded on the April data release providing additional ownership data for all skilled nursing facilities (SNFs) enrolled in Medicare, approximately 15,000 nursing homes. And recently, in December, CPI released ownership data on an additional 7,000 hospitals. We continue to update the ownership data of hospitals and nursing homes and will update releases quarterly.

For 2022, we also have a process called the Vulnerability Collaboration Council which identified the top Program Integrity risks that lead to fraud, waste, and abuse in the federal programs administered by the agency. And vulnerabilities identified and addressed involve known areas for fraud and abuse on a national scale. An example was the numerous COVID healthcare fraud schemes that came out during the pandemic. For most of the vulnerabilities flagged, we can mitigate the harm of the provider's fraudulent activities on our beneficiaries. We removed the providers from the Medicare program and put controls in place that would make it harder for the schemes to continue and be pervasive.

In 2023, nursing homes will be a priority. We will continue our efforts in supporting the President's initiative to improve nursing home quality and care. CPI continues looking for additional methods to ensure ownership transparency, above and beyond what we've already done. CPI will continue to perform nursing home oversight. We work collaboratively with other components in the agency doing data analysis on the use of psychotropic drugs, which can cause serious side effects. CPI plans to analyze the nursing homes' use and use that data to perform our investigations and collaborate with other parts of the agency.

Another area of focus will be Medicaid-managed care. States use managed care to administer benefits to individuals enrolled in Medicaid and CHIP. In 2023, CPI will continue to ensure that states and managed care plans adhere to federal requirements relating to Program Integrity. We will ensure compliance by auditing medical loss ratio calculations and reporting. We will continue to offer assistance and education and perform oversight of managed care plans, Program Integrity, and compliance plans. This oversight activity is important because it ensures that beneficiaries receive quality care and that outcomes in the Medicaid program are sustainable for years to come.

This concludes my remarks on CPI's focus areas for '23. We look forward to rolling up our sleeves and accomplishing our challenging but important work of Program Integrity. So now I shall turn it over to my colleague Dr. LaShawn McIver for her remarks.

Dr. LaShawn McIver: Thank you, George. I'm the Director of the CMS Office of Minority Health. It is my sincere privilege to join you today to provide a brief update since our last call. CMS OMH plays an important role in guiding efforts across programs. We help increase collaboration and integration across the agency and frame CMS's approach to operationalizing equity in partnerships with all our communities, individuals, and stakeholders.

Throughout 2022, we worked to move the needle on CMS's strategic pillar to advance health equity using the five priorities in our CMS Framework for Health Equity as a guide. Since most of our partners in the field don't work with just one CMS program, much of our work is focused on aligning our health equity approach as an agency. CMS OMH released two frameworks in 2022 to support aligning our approach to health equity. The CMS Framework for Health Equity 2022- 2032 sets the foundation. It identifies five health equity priorities for CMS' work that focuses on standardized data, assessing causes of disparities, building the capacity of healthcare organizations and workforce, advancing language access, and increasing all forms of accessibility to healthcare services.

These priorities will continue to inform CMS's efforts for the next ten years and how the agency may operationalize each priority to achieve health equity and eliminate disparities. Each priority reflects the key area in which CMS stakeholders from underserved communities expressed that CMS action is needed and critical to advancing health equity. Together, the five priorities provide an integrated approach to building health equity into existing and new efforts by CMS and our stakeholders.

The second framework, CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, applies a geographic lens to new and ongoing agency activities by working across our programs to promote access to high-quality, equitable care in rural, tribal, and geographically isolated communities. This framework further advances the five priorities of the CMS Health Equity Framework by applying a community-informed geographic lens. In addition, our stakeholders have asked CMS to focus on expanding the collection and stratification of data across our programs, considering health equity focus measures and working to increase the availability of and access to CMS data for researchers and our external partners. Without this vital data, we cannot see disparities or know who is most impacted and where gaps exist. Therefore, we released a report in 2022, The Path Forward: Improving Data to Advance Health Equity Solutions. This report outlines the current state of health equity data collection across CMS programs, details progress to date in improving CMS data collection, and defines CMS' future actions to continue to improve health equity data. Lastly, in 2022, we awarded our grantees for the Minority Research Grant Program, which helps to support researchers investigating or addressing healthcare disparities. For more details on the grantees and their projects, I encourage you to visit the minority grant research web page.

In 2023, CMS OMH looks to continue integrating health equity into existing and new efforts by CMS via implementation of the priorities within the aforementioned frameworks, prioritizing health equity data improvements across the agency, furthering our outreach for our coverage to care initiative throughout the nation, increasing capacity building for healthcare organizations and the workforce, and collaborative engagement, both across the agency and with stakeholder agencies within the communities we serve, to ensure CMS is hearing the health equity requests of our partners and holding ourselves accountable those we serve.

In closing, I thank you again for the opportunity to share just some of the incredible work underway to advance equity. I look forward to our continued partnership on this important journey. I will now turn it over to Dr. Mary Greene, the CMS Director of the Office of Burden Reduction and Health Informatics.

Dr. Mary Greene: Hello, everyone, and thank you for all you do and everything you do to serve patients who are seeking healthcare. Our Office of Burden Reduction and Health Informatics is about improving experiences and enabling efficiencies in the healthcare enterprise. We look for opportunities to reduce administrative burden through changes in policy or technology, or operations to keep everyone's focus on delivering high-quality care. We work to advance interoperability and use national standards to make data when, where, and how it's needed so people can gain insights from the data to make decisions. And we engage beneficiaries in the medical community to inform this work and the solutions that come from it.

In 2022, we used human-centered design to understand the experiences of people living with and treating chronic pain, including barriers to care and factors affecting the quality of care and their quality of life. We also completed related work in behavioral health to understand the barriers to accessing prevention, treatment, and recovery services for Substance Use Disorders. And we engaged stakeholders to understand barriers to accessing oral healthcare for children and adults eligible for Medicaid. We are using the insights to inform and engage policy folks across CMS and HHS to think about what we can do to address these barriers.

We also posted two Requests for Information (RFI) in 2022. The Make Your Voices Heard RFI gave us valuable insights on topics like challenges patients face, which is a recurrent theme in everything we've been doing this past year and provider experiences delivering care. We received ideas on opportunities to advance health equity in our programs and the impact of the flexibilities provided during the COVID-19 PHE.

The National Directory of Healthcare Providers and Services RFI explored the concept of CMS creating a directory that would go beyond the traditional provider directory to include information on healthcare providers, payers, and services. We sought comments on how a CMS-led directory could serve as a hub for directory and digital contact information.

In December, we published two proposed rules to address prior authorization. Prior authorization is an important utilization management tool, but when it's onerous to get through the process, that's a problem for everybody involved. Patients may unnecessarily pay out of pocket or abandon treatment altogether when prior authorization delays care. Prior authorizations is also a leading cause of burnout among clinicians, and payers have to redo work when they don't receive

the information they need to make decisions upfront. Ensuring prior authorization is efficient, transparent, and standardized is critical to ensuring timely access to care. The Interoperability and Improving Prior Authorization proposed rule is intended to enhance patient and provider access to health information and to streamline prior authorization processes across different sources of health coverage. It proposes new requirements on payers to improve the electronic exchange of health data and support prior authorization. And it also proposes timeframes around how quickly some payers would need to respond to prior authorization requests and require payers to publish certain metrics around the rates of approval and appeals. Sometimes, in the prior authorization process, providers need to send more complete clinical information to payers, such as medical charts, x-rays, and referral documentation. That's where the Attachments Proposed Rule comes in. The Attachments Proposed Rule includes standards for "health care attachments" transactions, which would support healthcare claims transactions and prior authorization transactions. So together, these two rules ensure that patients, providers, and payers have the information they need to get through the prior authorization process and make a decision faster. So patients can get the care they need more quickly. It gives patients more visibility into how plans handle prior authorizations, and that information might be helpful to patients when they select the health plan they want to join.

And finally, the rules help make the technical approach more standardized across Medicare, Medicaid and Marketplace programs, making it easier for providers to navigate the prior authorization process. The comment period for both those rules ends in March. So, in 2023, we look forward to continuing to review and receive comments on the proposed rules I mentioned. We will also continue to review comments from the RFIs we published and launch new human-centered design studies.

We will also share insights from this work with our colleagues across the agency to explore additional opportunities to improve experiences for patients, providers, and other stakeholders. And to enable efficiency in the healthcare system to improve health outcomes for the people we serve. So thank you for informing the work we do, and let's keep the conversations going. I will turn it over to Bruce Alexander for the question and answer session.

Bruce Alexander: Thank you, Dr. Greene, and to all of our speakers today. As I mentioned earlier, we solicited questions before the call, and we will touch on a few because we are short on time. Our first question is for Dr. Seshamani. How does CMS see IRA implementation going? What is CMS focused on? And how can stakeholders be helpful to the agency?

Dr. Seshamani: Thank you, Bruce. We have hit the ground running with implementing the Inflation Reduction Act. As we have spoken about meeting our timeline for January 1st for vaccines at no out-of-pocket cost for those with Medicare, we have a cap on a month's supply of covered insulin at $35. And moving forward, it is important to get input and feedback from all of you on the various provisions we will be implementing, including the Drug Price Negotiation Program. We recently released, last week or the week before, a timeline of the various pieces that will be put in place to implement this program. And we want to ensure that we get all of your input as we think through how to most thoughtfully implement this program to realize the benefit and impact of this legislation for the millions of people who rely on Medicare.

Bruce Alexander: Thank you, Dr.Seshamani. We are tight on time. That's going to wrap up our question-and-answer session. We will have the remaining questions and answers in our next call for you. I want to thank all of our speakers today. And thank everyone that joined today's national stakeholder's call. We're conducting these calls quarterly. So please keep an eye out for the invitation for our next quarter. With that, I would like to turn it back to our Principal Deputy Administrator and Chief Operating Officer, Jon Blum, for closing comments.

Jon Blum: Thank you, Bruce. And thank you to all our CMS speakers. And thank you to everyone that joined us today. Your work, feedback, and comments strengthened CMS programs during 2022. And we are very hopeful that you will stay engaged for 2023.

As folks here mentioned, we have a huge agenda this year, and we look forward to staying in touch and sharing progress and data points. But back to that first theme, please stay engaged. Please give us comments. And please help us make CMS programs better. So, with that, we'll stop here. I look forward to seeing you next quarter. And please stay in touch.