Centers for Medicare & Medicaid Services
Quarterly National Stakeholder Call with CMS Administrator
April 25, 2023
1:00 pm-2:00 pm ET

Webinar recording:
https://cms.zoomgov.com/rec/share/ehOpfo5vCGSUbpw-UMBExmyOWG78wojx9fG9xj9m62BU3Bgn4oaA0llwI5NC-7g.umqnXhBLpm-I3WVn
Passcode: &@O.03Us

Bruce Alexander: Hello, and welcome to everyone on the call today. My name is Bruce Alexander, I am the director of the CMS Office of Communications. Thank you so much for joining us today for our second Centers for Medicare & Medicaid Services National Stakeholders Call for the year. I'm going to walk through today's agenda and then turn things over to our speakers. Before I do that, I have 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 and media questions should be submitted using our media inquiries form, which may be found at cms.gov/newsroom/media-inquiries. We will not be accepting live questions, however, we did solicit questions beforehand, and we will answer a few of those today. Everyone should be able to see today's agenda on the screen and we have a full agenda that includes the CMS Administrator, Chiquita Brooks-LaSure, and her leadership team providing an update on recent CMS accomplishments and how our cross-cutting initiatives are advancing our strategic plan. These presentations will be followed by a question and answer session. With that, I will turn it over to our leader and Administrator, Chiquita Brooks-LaSure. Administrator?

Chiquita Brooks-LaSure: Thank you so much, Bruce. Good afternoon to everyone here on the east coast. Good morning to those of you who are on the west of us. Thank you so much for joining today's call. We have a great agenda, and I'm excited to hear your feedback about the work that we are doing to deliver better health to the people we serve. Before we get to our other speakers, I'm going to highlight a few of our achievements this year. Working alongside all of you, our amazing partners, we have made great strides to advance health equity, expand access, engage partners, drive innovation, protect our programs, and foster operational excellence. With these six strategic pillars to guide us, we are tackling the unfinished business of the Affordable Care Act and implementing the exciting new prescription drug policies in the Inflation Reduction Act. Many of you remember back in 2014, celebrating 8 million enrollments in the health insurance marketplaces in its first year. I'm truly proud to say, we have doubled that enrollment this year. 16.4 million people selected plans during this year's record-breaking open enrollment. That's 4.4 million more people than our last open enrollment and includes an increase among Hispanic and Latino people compared to last year's already historic strides.

While we are making incredible progress with record enrollments in Marketplaces, ensuring health care is equitable and affordable are also top priorities. We finalized several policies in the 2024 Notice of Benefit and Payment Parameters Final Rule that advance equity, access, and affordability—including allowing Marketplace Assisters to provide more convenient and efficient help to people who are seeking Marketplace plans. We're also continuing our work to

lower drug prices and increase coverage for the people we serve. Thanks to the new prescription drug law, the Inflation Reduction Act, people with Medicare are already saving on insulin and vaccine costs. As of April 1, people with Medicare may pay a lower coinsurance for some drugs with price increases higher than inflation as part of the Medicare Prescription Drug Inflation Rebate Program. We're also right on schedule with another major reform of the new drug law, the Medicare Drug Price Negotiation Program. In September, we will announce the list of 10 Part D high-spend brand-name drugs to participate in the Negotiation Program. We are working closely with all parties to ensure that people with Medicare pay fair prices for some of the costly medications, beginning in 2026.

When it comes to health equity, we're pulling all our levers to defend people's right to health care. Alongside our successes in the Health Insurance Marketplace and our ongoing work to lower drug costs, we're also working to strengthen access to Medicaid and CHIP. As you know, we are interested in putting forth proposals to strengthen access to services in Medicaid and CHIP both in fee-for-service and managed care and we look forward to sharing more about these proposals soon. We are also working closely with states to transition back to regular Medicaid eligibility operations. A process we call "unwinding" but that is also referred to as "renewals." Deputy Administrator Dan Tsai will be speaking later today about our ongoing collaboration with states to make this transition as smooth as possible and our work to ensure individuals who are eligible for Medicaid or CHIP retain their coverage.

Also, we announced a temporary Special Enrollment Period for the Health Insurance Marketplaces, which we refer to as the "Unwinding SEP." Throughout the unwinding period, people who lose Medicaid or CHIP can take advantage of the unwinding SEP to sign up for health care coverage through HealthCare.gov. They may also find the same SEP at their state-based Marketplace in participating states. It is one of our top priorities to ensure that people know the steps they need to take to maintain coverage or where to turn next if they are no longer eligible for Medicaid or CHIP. Your partnership is essential to our success. Today, we are asking all of you to leverage your resources and networks to help us to reach as many people as possible. Working together, we can maximize our outreach and minimize the loss of coverage. Please urge anyone enrolled in Medicaid or CHIP to contact their state Medicaid agency today to make sure their agency has their correct contact information. They can find their state's contact information at Medicaid.gov/renewals. Many resources are available and frequently updated on our dedicated website, Medicaid.gov/unwinding.

Another critical lever in our effort to advance health equity is the Medicare Advantage program. Last month, we shared the 2024 Medicare Advantage and Part D Rate Announcement and the 2024 Medicare Advantage and Part D Final Rule. In addition to ensuring that people with Medicare Advantage receive timely access to necessary medical care and protecting them from confusing or potentially misleading marketing materials, our recent program updates will strengthen Medicare by holding health plans accountable for delivering quality health care for all seniors and people with disabilities. Paying Medicare Advantage plans more accurately for the care they provide is how we remain good stewards of taxpayer dollars and ensure that people enrolled in Medicare Advantage, especially vulnerable populations, and people in underserved communities, can continue to access the care that they need. Our final policies will lead to better

care for all populations covered under our programs, including people in rural areas, communities of color, and those who are dually eligible for Medicare and Medicaid.

Before I close, I would like to highlight Black Maternal Health Week, which is observed every year from April 11 through April 17. CMS is committed to tackling the country's maternal health crisis. During Black Maternal Health Week, we participated in events to help raise awareness and build coalitions to address the disparities impacting pregnant Black and Brown women. I joined the men's basketball team at Howard University in a roundtable discussion to kick off this important week. The team's players and managers are committed to bringing awareness to the maternal health crisis among Black women, and I was really inspired by their efforts and their insights. It was really remarkable to hang out with the next generation of young men and women and listen to how much they cared about their mothers, their sisters, and their classmates, as well as the women who are interested in pursuing maternal health in their future careers. I shared with them what CMS is doing to address the disparities like our work to expand Medicaid and CHIP coverage. To date, 32 states and the District of Columbia have expanded Medicaid and CHIP coverage for 12 months postpartum. It's amazing that every time I talk about maternal health, this number ticks up where we have more states, and we don't want to stop until we hit all 50. We have made amazing strides towards their mission of delivering better health to all people. My colleagues from CMS' Centers and Offices have even more to share, so now I'm going to turn it over to CMS Principal Deputy Administrator and Chief Operating Officer, Jon Blum, who will give a CMS operations update.

Jon Blum: Thank you so much. I wanted to share this slide with the folks who have joined us today. One of the goals we have for this call is to not only talk about the policy developments that CMS has made during the past quarter, but also to talk about how we are changing the agency to really focus on being best in class, whether it's how we operate, how we pay claims, how we engage. One primary goal for the agency is that we are operating to support your work, but also to really set the overall model for how the health care system should work. During the past year or so, we have spent a lot of time thinking about what our data strategy should be. And the thing that we focus on, we want to use data to make better decisions going forward and use all the data that gets generated, not just to help the health care system transform, but to help CMS make the best policies going forward. Our teams have come together and have first focused on these seven core principles.

We want CMS data to be high-quality, but we want CMS data to be able to be used, not just by us, but by the whole health care system throughout the country. CMS will take these seven principles, thinking about accountability, thinking about using data that's responsible, for example, and begin to turn it into a full action plan for how we want to move forward. And so, if you are a CMS contractor doing work with CMS today, one of the changes you will see is that we want CMS data to always be shared, always be usable, and to live within the CMS ecosystem. If you are a health care provider, we want to make sure that you have access to the information you need to change care for the better; for example, to succeed within one of our CMS payment models. If you are a health care policy researcher, we want you to have access to data, so it is low cost, so it is simple to use. You can really help us make better policies going forward. If you are a health care patient, we want you to know that we hold data to be one sacred trust that CMS will always protect to ensure that it stays confidential. So, as folks work with

CMS going forward, whether it be a payment system or a brand-new model CMS is testing, please note that we are focused to ensure that we have more data resources, that we have best-in-class data systems, and that we can all use it to inform CMS policy going forward.

So, please stay tuned for more from us, but also, please know that we understand that CMS data is a core asset for all of us to use, and CMS wants to be best in class for how we use it, share it, and keep it safe going forward. With that, we will turn it over to our Chief Transformation Officer for the Center for Medicare, Dr. Doug Jacobs. Doug, take it away.

Dr. Douglas Jacobs: Thank you so much. I am Doug Jacobs. Thanks for joining us today. Our Center for Medicare team is driving towards the future where more than 64 million people with Medicare have access to receive equitable high-quality and person-centered care that's affordable and sustainable. We know that all parts of Medicare are key to success in this effort. I'm going to spend some time today talking about our recent work on the Inflation Reduction Act, Medicare Advantage, and Traditional Medicare. As the Administrator mentioned, we are right on schedule with implementing the new drug law, the Inflation Reduction Act. As of January 1st, people with Medicare prescription drug coverage pay no more than $35/month per covered insulin. And recommended vaccines are available without cost-sharing. Changes to Medicare Part D will make a real impact in helping people with Medicare afford their medications. Starting in 2025, prescription drug out-of-pocket costs will be capped at $2,000.

Additionally, people with low incomes will have extra help affording their medications. CMS has made progress on implementing the drug negotiation and inflation rebate provisions of the drug law by issuing draft guidance documents for public comment over the last couple of months. We anticipate issuing revised guidance for drug negotiation this summer. These documents and your comments on them are critical for CMS to meet the September 1st deadline to publish the list of 10 Medicare Part D drugs selected for negotiation. We have appreciated your partnership and feedback to date. We know that you need to know what's coming when and what the opportunities are to collaborate with CMS. You may have also seen that we recently issued two major rules that cover Medicare Advantage. Our goal is that Medicare Advantage stays strong for people with Medicare, as it's an important option for beneficiaries.

The goal for both the 2024 Medicare Advantage and Part D Final Rule and the 2024 Advance Notice/Rate Announcement were to make sure Medicare Advantage meets the health care needs of all beneficiaries while improving the quality and long-term stability of the Medicare program. That's why we are implementing a breadth of policies that are impactful in how much they will protect and help beneficiaries against deceptive marketing and provide them accurate information, improve timely access to care, strengthen access to behavioral health, incentivize high quality care for underserved populations, and make accurate payments. As with all final rules, the next step is how these provisions get implemented on the ground. It will be important for us all to hear how it is going and what we are learning. This will help us make refinements over time to continue to strengthen the program. Our recently announced payment rules for Traditional Medicare also builds on efforts to further equitable, high quality, and person-centered care.

Under the recently announced Fiscal Year 2024 Inpatient Prospective Payment System, CMS proposed to recognize the higher costs that hospitals incur when treating people experiencing homelessness when hospitals report social determinants of health codes on claims. This means that CMS would more accurately pay hospitals and recognize for the first time that homelessness impacts resource utilization. This proposal, coupled with proposals that reward health equity in hospital and nursing facility value-based purchasing, are examples of how we are creating incentives for hospitals to provide excellent care for underserved populations. With that, I will turn it to Jeff Wu, Deputy Director for Policy of the Center for Consumer Information and Insurance Oversight.

Jeff Wu: Thanks, Doug. I'm excited to share with you that we just celebrated the 13th anniversary of the Affordable Care Act (ACA) with record breaking enrollment. 16.4 million people selected plans during this year's record-breaking Marketplace Open Enrollment period. We know these incredible numbers are the direct result of this year's winning combination of record affordability thanks to the Inflation Reduction Act, robust plan options, an improved consumer experience, and large-scale outreach and enrollment assistance. We recently released the 2024 Payment Notice, which builds on the Affordable Care Act's promise to expand access to quality, affordable health coverage and care by increasing access to health care services, including behavioral health, simplifying choice and improving the plan selection process, making it easier to enroll in coverage, strengthening markets, and bolstering program integrity. This rule advances health equity by improving consumer protections and removing barriers to access coverage – specifically in the areas of network adequacy, re-enrollment, health plan options and choice, health plan marketing names, modified annual household income verification and through providing a new special enrollment period for those who lose Medicaid or Children's Health Insurance Plan (CHIP) coverage and door-to-door Assister outreach to help consumers enroll in coverage.

As folks know, unwinding has officially begun. I want to emphasize that the Marketplaces across the country are ready to support individuals who are no longer eligible for Medicaid or CHIP coverage. Marketplace coverage is more affordable than ever before; we're approaching outreach, marketing, and enrollment assistance like it's Open Enrollment, and the Marketplaces have adopted a variety of policy and operational flexibilities, including our continuous Special Enrollment Period at HealthCare.gov. I would like to turn it over now to Dan Tsai, CMS Deputy Administrator and Director of the Center for Medicaid and CHIP Services.

Dan Tsai: Thanks, Jeff. I'm going to hit on a few things for Medicaid. I think as folks know, we have highlighted some overall priorities to advance coverage and access to advance health equity and fully support innovation and whole person care. We're over 90 million people strong now in terms of people having comprehensive coverage through Medicaid, which we are very proud of. Three things I wanted to highlight. The first, as you heard just now from Jeff and as you heard from the Administrator, is Medicaid renewals or the unwinding from the Public Health Emergency, restarting Medicaid redeterminations, whichever term folks are using. That remains the top immediate policy and operational priority for the agency from a Medicaid standpoint, focusing on preserving coverage to the greatest extent possible as we undergo Medicaid renewals for the first time in three years. Many of you in the community are deeply engaged with us, so I won't go through all the many things happening. This is probably the most significant coverage

shift in the health care landscape in quite some time. Our goal is to make sure that folks remain covered, whether through remaining eligible for Medicaid, getting over to, in many cases, free or highly subsidized coverage in the Marketplaces, getting over to employer-sponsored coverage, or Medicare or to any other coverage option. Congress has established a framework on the timing that states have where we are allowed to start initiating renewals, as well as the parameters and rules that we at CMS have put out. There are hundreds, if not more, pages of guidance and detail and we've had individual discussions and collaboration with states to make sure that states are as prepared as they can be. So, much more to come over the coming year. We have on Medicaid.gov a range of resources including the general distribution of timing for when the various states are each undergoing their renewals. We appreciate all of your support -- the providers, the advocacy groups, health plans and the broader community – it really is a team effort.

Second, I want to note a few things where we have been pushing ahead and forging with state and other partners, substantive new policies that help advance equity and coverage. Last week we released a State Medicaid Director Letter outlining 1115 demonstration authorities for states to provide coverage to folks in the penal system for pre-release services between 30 to 90 days prior to release. We have one state where we have approved a significant 1115 demonstration. Congress, through the Support Act, authorized and directed us to be able to do that and that framework we put out and associated discussions with states with the many proposals is substantive and exciting and supportive of health equity. I want to flag within these health-related social needs, where we have continued to really establish a federal framework for what is the role of Medicaid and what guardrails like housing and nutritional support, and most recently, this past quarter, we approved an 1115 demonstration in New Jersey for many of those pieces.

Lastly, the category of new policies. As many of you saw yesterday, we released a rule with different parts of CMS, our Medicaid team, and partnerships with others around coverage for DACA beneficiaries and really creating a path to coverage for states that have elected the 214 options. It's really exciting stuff. We hope you all read every page of the rule.

Finally, for what's coming up, I just want to highlight we as an agency across CMS and across federal government, are continuing to put top priority on Medicaid renewals and preserving coverage and successful transitions of coverage. We have substantive rulemaking coming up. Stay tuned for that, on managed care, on access within the Medicaid program, but we are excited for comment on them, and we think they will be very groundbreaking. I think it would be accurate to say we got thousands of responses from the request for information on Medicaid access. We put that out some time ago. Lastly, a lot to come on school-based health care services, and reducing some of the barriers there as well. We are running short on time. I'm going to pause and pass it to Pam Gentry at OMH.

Pam Gentry: Thank you. It is my sincere privilege to join you today to provide a brief update on our first-quarter accomplishments and progress. CMS OMH plays an important role in guiding health equity efforts across CMS programs by increasing collaboration and integration across the agency and framing CMS'approach to operationalize equity in partnership with all of our communities, individuals, and stakeholders. The first quarter has been exciting, and we made a lot of progress. During the January stakeholder call, we laid out several priorities for CMS OMH

for 2023, one of which was collaborative engagement, both across the agency and with stakeholder agencies within the communities we serve to ensure that CMS is listening to the health equity requests of our partners and holding ourselves accountable to those we serve. I'm delighted to report that we announced an inaugural CMS Health Equity Conference that will be held at Howard University on June 7 and June 8. It will bring a diverse group of people to discuss health equity. It will also support initiatives through active engagement via conference participation, presenting health equity work, networking, and providing feedback. And we thank you for the great interest shown in this conference. So far, we have a waitlist for in-person participants, but we expect to be able to admit additional people. Our virtual registration is still available. The increased interest in health equity supports our ability to create a culture of equity that will be sustainable. Through collaborative engagement, we can diffuse a culture of health equity.

I would like to take a second to recognize the unwinding initiative that Dan has just spoken extensively about. I want to acknowledge the efforts our colleagues at CMCS are making to sustain eligibility. According to the Assistant Secretary for Planning and Evaluation (ASPE), unwinding is projected to impact approximately 15 million individuals, with approximately 6.8 million losing Medicaid coverage despite still being eligible. I'm sure this information is top of mind for many of you, as it is for CMS. We know children and young adults as well as Latino and Black people are most likely to be impacted. Knowing these predictions ahead of time, we hope that with your help, we can do everything possible to mitigate further disparities in coverage and access to health care. A proactive community outreach strategy will aid in ease of transition and serve as a safety measure to diminish the impact of loss of coverage. I encourage you to share the resources from CMS with your community. And once a person's coverage is confirmed, our Coverage to Care initiative offers resources for consumers and partners in up to 9 languages to help understand key terms and stay connected to regular care. Find more information by going to cms.gov/c2c.

In addition, one of our other key initiatives is to prioritize health equity data improvement across the agency. Without data, we cannot see disparities or know who is most impacted and where gaps exist. As the largest payer of health care in the United States, CMS can set the bar for meaningful health equity data collection and use across the health care system. Accurate and complete data elements support CMS in its efforts to create evidence-based policies and regulations and to assess how well these policies and regulations align with the needs of all communities and individuals CMS serves. You can learn more about this on our website and we will have a webinar on health equity data that you can view at go.cms.gov/cms.omh. I look forward to our continued partnership and I will now turn it over to Dara Corrigan, Deputy Administrator.

Dara Corrigan: Thank you so much. Thanks Pamela. My name is Dara Corrigan, and I'm the Deputy Administrator & Director for the Center for Program Integrity or CPI. Today, I have the opportunity to highlight some of our Q1 accomplishments and comment on some of our ongoing important work. One of CPI's key priorities is to ensure that we have effective and principled oversight of both the Medicare Fee-for-Service and Medicare Advantage programs. For well over a decade, CPI has been trying to finalize a rule that would ensure we could perform audits of the Medicare Managed Care Organizations. We achieved that goal in January of this year

when we finalized the rule called the Risk Adjustment Data Validation Rule that will allow us to audit Medicare Advantage organizations. The goal of any audit, not just these audits, is to hold providers, suppliers, and plans accountable if they received payments to which they are not entitled. Our final rule encourages correct reporting of patient diagnoses across the Medicare Advantage program, so that Medicare pays the correct amount.

The final rule represents a measured and balanced approach, which is the way we like to operate. It reflects careful consideration of public comments, which is critical to the way we work, and feedback received from stakeholders. I would like to now move on to discuss a nursing home disclosure rule that we also published last quarter, which is part of the greater theme that we have here at CMS, that transparency leads to greater consideration of data and analysis of the data so we can make better decisions.

The Biden/Harris administration is committed to improving the quality of care in the nation's nursing homes in many ways, including by increasing the transparency of ownership data. In support of this goal, CPI issued a nursing home disclosure proposed rule in February of this year. The rule and subsequent changes to our provider enrollment forms will require every Medicare skilled nursing facility and Medicaid nursing home to publicly disclose the details of every direct and indirect owner that oversees, manages, or operates a nursing home. Why are we doing this? This disclosure is critical because it allows us and others to analyze the ownership and management data and to see whether certain types of ownership have a positive or negative effect on the quality of care or cost of care. We want to make sure that the nursing home industry is more transparent. For-profit companies own the vast majority of nursing homes, about 70%. Increasingly, there have been acquisitions by private equity companies and real estate investment trusts. In addition, nursing homes frequently use other companies to provide various services. Generally, the public doesn't know what companies provide and which services health companies might be contracted to nursing home owners. Making this information available publicly empowers nursing home residents and their families to make more informed decisions about their care. Our hope is that this greater transparency will allow us to scrutinize how ownership types correlate with the quality of care and costs.

And finally, I would like to turn to another vulnerability that we've been focusing on this last quarter. We will continue to devote significant resources to this vulnerability throughout the upcoming year. For a very long time, decades, we have been conducting investigations and taking action when there has been fraud, waste, and abuse in the hospice program. Late last year, we became aware of a new vulnerability related to the hospice program involving the enrollment of many new potentially fraudulent hospice providers, in California, Nevada, Texas, and Arizona. We have been working with for-profit and not-for-profit trade associations and other staffers in Congress so that we can comprehensively address this vulnerability. I look forward to announcing some of these concrete steps at our next call. This concludes my remarks. I will now hand it over to my colleague, Dr. Lee Fleisher.

Dr. Lee Fleisher: Good Afternoon. I am Lee Fleisher, Chief Medical Officer for CMS and the Director of the Center for Clinical Standards and Quality, known as CCSQ. Like my other colleagues, there is never a dull moment in CCSQ. As you know, The Biden Administration announced that the COVID-19 Public Health Emergency (PHE) will expire at the end of the day

on May 11, 2023, and the CCSQ has worked diligently preparing providers and the health care system at large. In August of last year, CMS released a roadmap and several fact sheets for the eventual end of the PHE waivers and flexibilities. Most recently, we've released updated provider fact sheets and other supporting material that clearly delineates which flexibilities expire at the end of the PHE or will be extended in accordance with legislative changes enacted by Congress. For example, Congress extended many telehealth flexibilities. Since the onset of the COVID-19 PHE, CMS has always been committed to watching the data and pivoting, as necessary. This year in the Fiscal Year 2024 Skilled Nursing Facility Prospective Payment System Proposed Rule, we did just that for the Skilled Nursing Facility Quality Reporting Program. CMS is proposing the adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure beginning with the fiscal year 2026 SNF quality reporting program as well as modifications to the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure beginning with the fiscal year 2025 SNF QRP. Both proposals would align with the CDC's most recent guidance for vaccination. Also, in the FY 2023 SNF PPS proposed rule, CMS solicited public comments on minimum staffing requirements for nursing homes. We continue to review the feedback from the comment solicitation and other inputs, all of which will be used to inform proposals for minimum direct care staffing requirements in nursing homes in rulemaking this spring. And I would be remiss if I didn't mention the 2023 CMS Quality Conference, which will be held on May 1-3, 2023. To date, nearly 7,000 people have registered. For the first time, we are offering a third day focused on advancing quality, equity, and safety in America's Nursing Homes. You can sign up at cmsqualcon.com.

Lastly, we know all too well how burdensome some administrative practices are for providers reporting quality metrics across multiple programs. So, we are excited to launch a CMS initiative seeking to reduce the administrative burden for physicians by standardizing and better aligning measures used to report quality performance across our health care programs. This initiative prioritizes outcomes that are meaningful for patients and reduces burden and duplication for clinicians, facilities, and health insurers, while moving toward a building-block approach that will align across CMS' quality programs. This "universal foundation" of quality measures will apply to as many CMS quality-rating and value-based care programs as possible, with additional measures added on, depending on the population, or setting. I will now turn it over to Dr. Liz Fowler, CMS Deputy Administrator and Director, Center for Medicare and Medicaid Innovation, Liz?

Dr. Elizabeth Fowler: Thank you, Lee, and Administrator Brooks-LaSure. 2023 is shaping up to be an exciting year for the CMS Innovation Center. In February, the Innovation Center published a report in response to the President's Executive Order on Lowering Prescription Drug Costs for Americans laying out three new model ideas aimed at increasing access to innovative therapies and addressing drug affordability for patients. We hope that these models will build on and complement the provisions included in the Inflation Reduction Act that are implemented by my colleagues in the Center for Medicare. And another important milestone for the Innovation Center, the ACO REACH model started on January 1st. As we announced shortly after ACO REACH, participation in accountable care research models in 2023 is strong. An estimated 2.1 million beneficiaries are part of the program, an increase of about 300,000 from the 1.8 million who were part of the model in 2022. We are pleased that over 13.2 million beneficiaries in

Traditional Medicare will be served by over 700,000 health care providers and organizations through the Medicare Shared Savings Program, the Kidney Care Choices Model, and ACO REACH. The growth in accountable care participation is a strong indication that we are on our way to achieving the CMS goal of having all people with accountable care relationships with their health care providers by 2030.

We continue to be committed to transparency and clarity around our future path. Last year, the Center published a strategy, and we are now rolling out pieces of that by extending BPCI-A for two more years through 2025. The Request for Applications (RFA) for this extension period is open through May 31st, 2023, and we encourage Medicare-enrolled providers, suppliers, or Medicare Accountable Care Organizations (ACOs) to apply. We also announced an extension of the Medicare Advantage Value-Based Insurance Design model, or VBID, through 2030, along with some important policy changes. The model extension and policy changes build on the model's success to date and encourage an even greater focus on addressing health-related social needs, such as food insecurity, safe living environments, and transportation access, and enhancing the seamless delivery of care across settings.

On the research and evaluation side, the Innovation Center has released 6 evaluation reports since the beginning of the year. The evaluation team at the Innovation Center working together with the Learning and Diffusion Group, have also been working on a new initiative that we are calling the Transformation Initiative. We will be able to share more on this initiative and the transformation care delivery practices at the CMS Quality Conference, APHA, and Academy Health. Finally, the Innovation Center continues to prioritize engagement with interested parties. Over the last few months, folks from the Innovation Center traveled to North Carolina and Arkansas to continue conversations and work related to the state transformation collaboratives. In March, we held a beneficiary engagement listening session with over 500 registrants.

I would like to echo the Administrator's remarks. Your partnership is really essential to our success. Thank you for your continued partnership and for working toward a health care system that achieves equitable outcomes. I'm going to stop there. Thanks for being here today. Stay tuned for more information on new models to be announced in 2023. With that, I'm going to turn it over to Nancy O'Connor, Director of the Office of Program Operations & Local Engagement.

Nancy O'Connor: Thanks, Dr. Fowler. Hello, everyone. I'm Nancy O'Connor, the Director of CMS' Office of Program Operations and Local Engagement, or OPOLE. I'm delighted to share with you some highlights of our local engagement work. OPOLE coordinates the work of CMS' ten regional offices from Boston to Seattle. We have an office in Puerto Rico as well. The offices are headed by Regional Administrators, and their primary role is to be the eyes, ears, and spokespersons for CMS to local stakeholders across the country. We have been busy with a myriad of engagement activities. This past Fall, during the Medicare and Marketplace open enrollment seasons, we helped thousands of beneficiaries and consumers. We held over 1000 enrollment events for Medicare beneficiaries and Marketplace consumers, helping them understand their choices so they could make informed coverage decisions based on their needs.

Much of OPOLE's current work is centered around explaining to beneficiaries and their caregivers the important changes to Medicare brought about by the Inflation Reduction Act,

including the $35 cap on insulin out-of-pocket costs. We're also working to ensure health care consumers understand their rights under the No Surprises Act to protect them from surprise medical bills. And now that states are renewing their Medicaid and CHIP eligibility reviews, we are leveraging the voices of hundreds of community partners to help us inform Medicaid beneficiaries about the necessary steps they need to take to renew their Medicaid eligibility or transition to other health coverage if they're no longer eligible. Our local engagement teams work with provider groups, too. Each summer and fall, we explain to providers what CMS is proposing through its major payment rules like the Physician Fee Schedule and the Inpatient Prospective Payment rule. Likewise, we explain whatever changes we may be making to the conditions of participation or other quality-related rules. We always encourage providers to comment on these rules and to share the impact a proposed rule could have on their facilities and local economies. The feedback we receive helps to inform policymaking.

We view all of our engagement work through a health equity lens and with an eye toward reducing health disparities. For example, we are heavily focused on understanding the unique needs of our rural and frontier communities. In fact, OPOLE has a rural health coordinator in each one of our regional offices who serves as a dedicated point of contact for rural stakeholders. They take special care to understand the needs of rural stakeholders and to relay their stories back to policymakers in CMS' headquarters. That's a fundamental role we play in OPOLE: listening and then reflecting what we're hearing from stakeholders and communities across the country to those who make policy. And we are especially attuned to listening to and lifting up the voices of those who don't typically have a seat at the table. What I mean is stakeholders who were under-heard, underrepresented, and often underserved.

Earlier, I mentioned that we are working through hundreds of community partners. Our regional outreach teams are small but mighty. We realize we can't do it alone, and that we must rely on our local partners to educate and inform the public as part of our educational mission. Partners like you, who are trusted voices in your community. Partners that can leverage your own resources and networks to extend CMS' reach in the community. We want to collaborate and work with you as a partner to achieve CMS' goal of expanding access and advancing health equity in communities across the country, particularly those in underheard and underserved areas, so that we can better serve the public through our policies and programs. So now, I will turn it over to Bruce Alexander, Director of the Office of Communications, who will moderate the question-and-answer session. Bruce?

Bruce Alexander: Thank you, Nancy. As I mentioned earlier, we solicited questions prior to the call. We will walk through those now. Our first question is for Pamela Gentry. How has CMS moved the needle to ensure that all individuals will be served, including members of communities that are underserved, can equitably access all CMS benefits, services, and other support and coverage?

Pamela Gentry: I think everything my colleagues have mentioned today is part of that. CMS has moved the needle in a number of areas to ensure equitable access to health care coverage to all, including with President Biden, having expanding access to quality, affordable health care and coverage for all. Some examples have already been mentioned to you today. All three of our Medicare, Medicaid, and Marketplace programs are insuring close to 160 million people. The

growth in Health Insurance Marketplace enrollment and HealthCare.gov states that among the Hispanic population, our enrollment rates have increased by 26%, and with African Americans by 35%. And really, across the board for all the minorities we have served in underserved populations, their numbers have increased. Of course, you just heard about the ACO REACH. It has also reached underserved communities helping to close the racial and ethnic disparities among people with traditional Medicare and accountable care relationships. In 2023, both the Medicare Shared Savings Program and ACO REACH model will have more Federally Qualified Heath Centers, Rural Health Centers and Critical Access Hospitals than it did in 2022. It also tests innovative payments for providers who work with populations who are underserved and it amplifies beneficiary and provider organization voices that Nancy just talked about. We are also working to measure quality using standardized data, including social drivers of health in quality programs. We're working to incentive payment to reduce disparities, improve accessibility by expanding the workforce, and improve language access. It's a long list, but there are a lot of great things coming about.

Bruce Alexander: Thank you, Pamela. If we could have Dr. Liz Fowler take this next question. Is there is anything you can say about the ACO REACH program that started January 1?

Dr. Elizabeth Fowler: Sure. Thanks for the question. We launched the ACO REACH model this past January with the goal of increasing access to care and improving care for underserved populations. ACO REACH is the most advanced accountable care model we have tested at the Innovation Center. We are excited about the model and the opportunity it offers to test new concepts that might be incorporated in the future into the Shared Savings Program and become more widely available. It really laid the groundwork for our health equity strategy at CMMI. In fact, 48 organizations joined REACH in 2023 and 84 of the 99 participants in 2022 remain part of the model. An estimated 824 health care providers are safety net providers, including Federally Qualified Health Centers, Rural Health Centers, and Critical Access Hospitals -- more than double the number in 2022. Interest is strong for participants to test leading innovations to deliver integrated, comprehensive, and coordinated care to beneficiaries. This is a signal to us of a continued commitment to transforming care for beneficiaries.

Bruce Alexander: Okay, unfortunately, due to time, that wraps up our question and answer session. I want to thank all of our speakers today and thank everyone that joined today's national stakeholder call. We're conducting these calls quarterly, so please keep an eye out for the invitation to our call for next quarter. With that, I'd like to turn it back to Jon Blum for closing comments.

Jon Blum: Thank you, Bruce, and thank you to all of our speakers. I think you heard from just about every CMS speaker how we work with stakeholders and how we work with partners is one of our key goals. We have a core strategic goal that we are shaping policy, building policy to ensure that we listen, that we take careful consideration to your views. That will continue. These quarterly calls are but one small part of our overall strategy for how we engage. We thank you for taking the time. We look forward to seeing you here on the next quarterly call. We look forward to reading your comments. We look forward to seeing you in person and helping us shape the best possible policies for us going forward. With that, we will close. We can't thank you enough for taking time with us today.