Centers for Medicare & Medicaid Services
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Eden Tesfaye: Hello everyone, and welcome to the thousands of folks on this call right now. My name is Eden Tesfaye, and I'm an Advisor to the CMS Administrator for External Affairs here at the Centers for Medicare & Medicaid Services. Thank you so much for joining us today for CMS's third National Stakeholder Call of 2023. I'm going to go ahead and walk through some of today's call agenda and then turn things over to our speakers. But before I do that, I, of course, have a couple of housekeeping items to run through. This call is being recorded, and 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 during the call; however, we did solicit questions beforehand, and we will answer a few of those today. Everybody should be able to see today's agenda on their screen. Unfortunately, our CMS Administrator, Chiquita Brooks-LaSure, is not able to join us today.

As always, we have a full agenda that includes the CMS Principal Deputy Administrator and Chief Operating Officer, Jon Blum, and our leadership team, who will provide an update on CMS's recent accomplishments and how our cross-cutting initiatives are advancing CMS's Strategic Plan. These presentations will be followed by a Question-and-Answer session. And with that, I'm going to go ahead and turn it over to Jon Blum.

Jon Blum: Thank you so much, Eden, and thank you to our whole team here for joining us today, but also thank you to all the stakeholders that have joined today. One of CMS's core missions and core purpose is to engage stakeholders throughout the country, and these calls that we run are really part and parcel to our goals to ensure that we can talk directly to CMS stakeholders but also take feedback. The CMS staff and the team here will continue to travel throughout the country to ensure that we can take your feedback and to ensure that CMS programs are best for our country. Two years ago, CMS put forward its Strategic Plan, and that Strategic Plan was built based upon feedback, based upon calls like this. The CMS team here developed a plan that has six pillars that guide CMS work, that guide the day-to-day work, and the day-to-day focuses that we have. We have 13 cross-cutting projects that all touch different parts of CMS. All 27 offices and centers that CMS runs have their own plan that's tied to these six pillars. We track day-to-day, really month-to-month, quarter-to-quarter, 400 different metrics to help us take stock to our work, and to ensure that we are staying very much on track. Today you will hear from our team, and they will describe the progress and each project they will touch on, each different milestone, ties to these six different pillars.

I want to highlight several areas that you'll hear more about today. Our first CMS pillar is to help promote health care equity, and this year, for the first time, CMS held a conference totally

focused on this topic. We had 5,000 people throughout the country join us to help teach us, but also, teach the whole country how we can build a more fair and more equitable health care system. You'll hear more about that today. Second pillar, we are driving better coverage access, and today CMS covers nearly half the total US population. We're doing that through better program design and better subsidies. So, we are very proud that today CMS covers more people than ever before. But you will also hear about our deep concern today. As states go back to normal order, to begin to redetermine eligibility for state Medicaid coverage, we need everyone's help to ensure that we are doing strong outreach and communication to ensure that everybody eligible for Medicaid stays covered, and for those that don't, they find other sources for coverage—we are keenly focused there. Our third pillar is why we're here today, which is to engage partners. We want CMS programs to ensure that they reach, they touch, and they're shaped by folks that actually use the programs. We are very proud this month to help celebrate the 33rd anniversary of the ADA, Americans with Disabilities Act. CMS will continue to engage stakeholders to ensure that Medicare, Medicaid, and Marketplace work better for those that have disabilities. The fourth pillar is to drive innovation, and you'll hear more today regarding ways that we're shaping the Medicare program to cover services better to pay physicians better to ensure that those covered by the Medicare program have a higher quality of care. For example, you'll hear about new payment models that we are putting forward to help test ways for us to incentivize better primary care systems. You will hear more about CMS' work to protect CMS programs to put forward more integrity and more trust in our programs. For example, to think about ways for us to improve Medicare hospice benefits. Lastly, the sixth pillar is that CMS wants to be a place, a beacon, for best-in-class operations. We are focused right now on ensuring that we help to wind down the PHE to ensure that CMS will be prepared and ready for any scenario that we could face in the future, be it a pandemic or disaster, to ensure that we can help support your work no matter what the scenario is. We are preparing, for example, to switch payments for vaccines for COVID to have payers paid directly. So, our commitment to payers, providers, and consumers, is the CMS payment systems, and those that we regulate will be ready for the fall once COVID-19 vaccines change from direct government purchase to being delivered by the private sector. So, with that, we'll turn it over to our speakers. But I just want to say that we have made progress, and CMS will continue to make progress, we are tremendously grateful to all of our stakeholders to ensure that CMS programs work better, really, for the whole country. So, with that, will turn it over to our Director for the Center for Medicare. Meena, you're up next.

Dr. Meena Seshamani: Great. Thank you, Jon, and it's great to be here with all of you today. I'm Dr. Meena Seshamani, Deputy Administrator and Director of our Center for Medicare. As you may know, the Center for Medicare is continuing to make steady progress in our implementation of the Inflation Reduction Act. Thanks to the new drug law, more people than ever have access to quality, affordable health care, and people with Medicare are already feeling the benefits. Those with Part D coverage have been able to take advantage of these benefits since January, such as a $35/month cap per covered insulin prescription. As of July 1, those who use a traditional pump for their insulin and are covered under Part B or Medicare Advantage will also see this $35 a month copay cap. These changes benefit at least 1.4 million Americans with Medicare, including some people who previously were paying as much as $400 a month for life-saving insulin. The law also expands the Medicare Extra Help program to provide more eligible seniors and disabled people with help paying for their Medicare Part D premiums and cost-sharing for their prescriptions. We estimate that an additional 3 million people could benefit from this Extra Help

program, and we appreciate your help in getting the word out to people with Medicare who can benefit from these provisions.

Turning now to drug negotiation, your feedback has been, and continues to be, instrumental for our implementation of the Medicare Drug Price Negotiation program. You may have recently seen that we released revised guidance detailing the new program. As we set up the program and move through the negotiation process, we're making sure that patient experience and the needs of people with Medicare is a key focus. There will be additional opportunities for you to engage with us during the negotiation process, such as patient-focused listening sessions. And, as you all know, the spring is an especially busy month for Medicare payment rules. We issued several proposed rules earlier this spring, covering inpatient hospitals and other facilities. Collectively, those rules build on key priorities to advance health equity and support underserved communities, such as building on prior efforts to reward excellent care for underserved populations. Over the last few weeks, we issued a set of proposed rules for physicians and other outpatient settings. These rules are focused on ensuring the people we serve experience coordinated care focused on treating the whole person, considering each person's unique story and individualized needs—from physical health to behavioral health, oral health, and social determinants of health, all of which are so important to improve the health of people with Medicare. For example, CMS is proposing policies for 2024 that would create some of the most significant changes in behavioral health in the history of the Medicare program, including a new benefit for intensive outpatient program services, which fills a current gap in coverage when people with Medicare require levels of service more frequent than individual therapy outpatient visits, but less intensive than a partial hospitalization program. CMS also proposed increasing payment for crisis care, substance use disorder treatment, and psychotherapy. We are optimistic that we can make a profound and sustained difference in the behavioral health treatment of millions of Americans. But the most important and informed path forward is only possible with your thoughtful feedback on these proposed rules. So again, thank you for joining us today. And I'll now turn it over to Dan Tsai, Deputy Administrator and Director for the Center for Medicaid and CHIP services. Dan?

Dan Tsai: Thanks, Meena. Hi, everybody! Thanks for joining, and thanks for caring about what happens here at CMS, in particular, with our ninety-some million folks enrolled in Medicaid and CHIP. As you heard from Jon, we have a lot going on around helping folks maintain access to health care coverage, Medicaid or Marketplace, and other forms of coverage, and I will talk about that briefly. I will note that there have been a few other things happening in the Medicaid and CHIP world over the past quarter beyond Unwinding. I think many folks in our community know we have spent substantial time really proposing new regulations around access and managed care within Medicaid and the Children's Health Insurance Program, all of which are intended to help set a floor for the program across the country and thinking about the timeliness of access and how that applies to managed care, the sufficiency of rates across the Medicaid program, how we think about strengthening home and community-based services, and putting an extra emphasis on the adequacy of access to primary care for kids and adults, for mental health and substance use disorder providers for kids and adults, and for OB/GYN services. So, there is a lot, and I know our public comments period recently closed. I think we have got a few thousand comments that we are in the midst of working through. So, as folks know, we are in the midst of the rule-making process and will be evaluating all comments that come in. But I do emphasize

the importance of those as we think about strengthening, evolving, and pushing the program forward and how important things like core access to care across delivery systems, including managed care, are in the program. And we have done quite a bit around things for kids, including putting out some major guidance on school-based Medicaid and how to simplify that and really encourage localities and states across the country to utilize school-based Medicaid services to enhance access as much as possible, especially for kids with mental health and other challenges. This is a really exciting collaboration with the Department of Education.

So, given the brevity of this time, I want to spend a few minutes amplifying what we just heard from Jon at the outset on Unwinding. As most folks here know, for the three years of the Public Health Emergency, states had to maintain Medicaid enrollment for everybody covered within Medicaid. Starting April 1, federal statutes changed, and states are in various stages of having resumed their annual Medicaid eligibility renewal process. Our primary focus is making sure that people maintain access to health care coverage—so for many folks through maintaining eligibility for Medicaid, but also for ACA Marketplace plans, or employer-sponsored plans, or Medicare folks who are aging in or for other circumstances. We have been very concerned with the numbers that we have been seeing. We have all spent, including our state partners, the past two years pulling out all of the stops to prepare. We have seen very large numbers of terminations in the first few months, and the most troubling piece has been the high level of what we call procedural terminations—individuals being terminated for nonresponse, perhaps they did not get the mail, or they weren't aware the renewal process had started — and that has been very concerning to us.

We have emphasized and encouraged a number of things. One, is an all-hands-on-deck effort, including with our state partners, emphasizing and urging following the federal rules, and CMS acting in compliance, making sure that every individual enrolled in the program receives the full Medicaid enrollment process they are entitled to. That has been a substantial focus, and we have both supported and taken action with states to make sure they are in compliance with following all federal rules. But also, importantly, we have put out dozens and dozens of policy waivers and flexibilities and strategies that make the eligibility process easier, more streamlined and help managed care plans outreach more, and allow states to also hold off on procedural terminations, all of which will have the effect of keeping eligible people covered. We've called on every state to take up every one of these options, and we have seen varying levels of uptake to some of those pieces. Suffice it to say that this is our primary policy and operational focus. This is the most substantial health coverage event that we have in the country at this point, and it really is an effort far beyond Medicaid and CMCS. It is certainly across all of the different components of CMS, and across multiple parts of the federal government, and with many of you all as external partners. We are also asking for you all to help raise awareness and help individuals stay covered. With that, I'm going to pause there, underscoring that importance, and we will turn it over to Jeff Grant, the Deputy Director for Operations in the Center for Consumer Information and Insurance Oversight (CCIIO). Jeff?

Jeff Grant: Thanks, Dan, and I guess we are all very aware of the Medicaid redeterminations at this point. And what I would like to talk about is what Marketplaces have done, first to prepare, and now we are in the execution phase, to be that appropriate landing spot for many of the folks that are no longer eligible for Medicaid and CHIP. The first big thing is the Special Enrollment

Period, which is available in the event of a loss of Medicaid and CHIP, and it runs through July of next year. Coupled with that, we have record-breaking affordability, really just amazing subsidies now available, and HealthCare.gov is a terrific resource for folks who lose coverage throughout the entire Unwinding period. But with that said, we know that we really need to reach these consumers and that we have got to get outreach and communication in place to get people to our front door so that they actually do see the affordable options that are there for them and can make an appropriate choice.

Our work includes a lot of Open Enrollment style outreach and advertising campaigns, you may have seen these already, this is to target folks that are disenrolled for Medicaid CHIP. We also put out historic levels of funding for the Navigators, who are now doing direct outreach, and they have always supported folks enrolling in coverage. On the direct outreach front, we have ramped up communications in the traditional ways that we communicate with individuals, but we ramped it up for those who lose Medicaid and CHIP and whose contact information is sent to us in a Marketplace. This includes additional text, e-mail, and phone outreach and an additional reminder letter that we are sending in the mail to them. Then on top of that, Navigators are conducting direct outreach to individuals in their local communities who lost Medicaid or CHIP coverage and haven't secured coverage after the first few weeks—this is really kind of the most exciting thing for us, to be able to create this new process, which we have never done before for this group of consumers. Matching consumers with assisters in their local area ensures that they can access in-person help, and if desired, we give them organization name recognition and ensure consumers are able to interface with assisters who best understand the community and the coverage options available in that community. Finally, we know everybody is interested in the data. We have not yet gotten data out of the door, but we are getting close, so we encourage you to stay tuned and expect more from CMS here in the coming weeks and months as we process and link data sources to try to tell the story of what is going on with Unwinding in a way that everybody can understand how this is running. With that, I will turn it over to Dr. Lee Fleisher. Lee?

Dr. Lee Fleisher: Good afternoon and thanks so much, Jeff. I am the Chief Medical Officer for CMS and the Director of the Center for Clinical Standards and Quality, known as CCSQ. Since our last call, the COVID-19 Public Health Emergency, or PHE, ended on May 11, 2023. CCSQ worked diligently to ensure that providers and the health care system at large were well-informed and had the necessary resources to return to normal operations. As a reminder, in 2022, the agency launched CMS National Quality Strategy, which is an ambitious, long-term initiative that aims to promote the highest quality outcomes and safest care for all individuals. This strategy builds on previous efforts to improve quality across the health care system, incorporates lessons learned from COVID-19 Public Health Emergency, and addresses the urgent need for transformative action to advance toward a more equitable, safe, and outcomes-based health system for all individuals.

CCSQ continues to implement much of our efforts under the framework of the National Quality Strategy. I will provide highlights and recent accomplishments. In April, CMS published a strategy for Organ Procurement Organizations, or OPOs as we call them. OPOs are nonprofit organizations responsible for the procurement, distribution, and transplantation of human organs in a safe and equitable manner for all potential transplant recipients. They serve an essential role

in supporting donor families, clinical management of organ donors, and professional public education about organ donation. As a part of the strategy, we also released the 2023 OPO Public Performance report, which reflects the first full year of performance for the 56 OPOs nationwide. On May 1-3, 2023, CMS convened nearly 10,000 health care leaders, advocates, patients, and families for the 2023 CMS Quality Conference, focusing on Building Resilient Communities: Having an Equitable Foundation for Quality Health Care. While the conference has been virtual for the last two years, we look forward to offering an in-person option in 2024, and details are forthcoming, but the 2023 conference is available online at www.cmsqualcon.com. In June 2023, CMS issued the proposed procedural notice outlining a new Medicare coverage pathway to achieve more timely and predictable access to new medical technologies for people with Medicare. The new Transitional Coverage for Emerging Technologies, or TCET as we call it, for Breakthrough Devices, supports improved patient care and innovation by providing a clear, transparent, and consistent coverage process while maintaining robust safeguards for the Medicare population.

As of July 6, 2023, broader Medicare coverage is now available for the Biogen and Eisai's Leqembi, the brand name for lecanemab, following the FDA's (Food and Drug Administration) move to grant traditional approval to the drug that treats individuals with Alzheimer's disease. With the FDA's decision, CMS will cover this medication broadly while continuing to gather data that will help us understand how the drug works. Again, these are just a few highlights of our efforts, and certainly, it is not an exhaustive list of everything. We know that there are also questions regarding the next steps for the Birthing-Friendly Hospital Designation. As you may recall, CMS unveiled the logo for the designation this past December, with the first-ever We Can Do Better: Advancing Maternity Care Together—Maternal Health Convening. The designation will be posted on CMS' Care Compare website and on the websites of participating health plans to indicate which facilities have received the Birthing-Friendly Hospital Designation this fall for the first time. We look forward to providing you with additional information soon. Now, I will turn it over to Ellen Lukens, Deputy Director, Center for Medicare and Medicaid Innovation.

Ellen Lukens: Thank you, Dr. Fleisher and Principal Deputy Administrator Blum. Thanks to all of you for taking the time to be with us today. I am Ellen Lukens, and I am the Deputy Director for Policy at the CMS Innovation Center. Last month, as Deputy Administrator Blum referred to, the CMS Innovation Center announced a new primary care model, the "Making Care Primary Model" or MCP. Despite the well-documented benefits of primary care for patients, fewer people in the U.S. report a regular source of primary care compared to countries with better health outcomes, particularly among underserved populations. By many accounts, primary care is in urgent need of investment and support. Decades of inadequate payments, increasingly complex delivery of care, and growing administrative burdens have all taken a toll on primary care. These challenges were exacerbated by the pandemic. More needs to be done to create pathways for primary care providers and practices to join value-based care, which has the potential to address these challenges. That is where Making Care Primary comes in. Making Care Primary builds on previous CMS Innovation experience with primary care model tests. These primary care tests support primary care practitioners and make advanced primary care available and sustainable for a more comprehensive pool of participants serving a broader and more diverse set of patients to improve quality, health equity, and overall patient care.

Four factors differentiate this model. The first is that it provides an on-ramp for safety net providers and small or independent primary care practices. Making Care Primary makes it possible for more safety net providers to participate, including Federally Qualified Health Centers (FQHC), through upfront infrastructure payment and payment adjustments to better support providers caring for underserved populations. The second is state partnership. Previous models have had a broad geographic scope. With this model, we are focused on fewer states and greater depth. We are launching Making Care Primary in eight states (Colorado, North Carolina, New Jersey, New Mexico, New York, Minnesota, Massachusetts, and Washington), where we are collaborating with state Medicaid agencies to achieve meaningful multi-payer alignment. The alignment approach includes support for primary care across Medicare and Medicaid in all participating states. The third is that this is a longer model test. It takes time to demonstrate results and achieve transformation, particularly in parts of the health system that have been historically under-resourced. For that reason, Making Care Primary is set to run for 10 years instead of the usual five years. Fourth, integration of primary care and specialty care. The model includes elements and strategies to drive better integration of primary and specialty care. For example, by supporting electronic consultations and co-management for patients with chronic conditions that require their providers to work more closely together. We anticipate releasing a request for applications later this summer, and we will open the application period around the same time. The model itself will launch on July 1, 2024.

Speaking of specialty care, we're excited that the Enhancing Oncology Model launched July 1. 561 oncology sites across 34 states will be actively seeking ways to enhance the quality of care furnished to Medicare patients undergoing treatment for cancer. Finally, last week, the Innovation Center also published a Request for Information to gather public input on the next round of episode-based payment models. Comments are due August 17, and we encourage and welcome feedback to questions that will help inform this next model. I will stop there, thanks 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 Dr. Aditi Mallick.

Dr. Aditi Mallick: Thank you Ellen, and thank you everyone for joining us today. My name is Dr. Aditi Mallick, and I am the Acting Director of the CMS Office of Minority Health. I am grateful to join you today to provide a brief update on our office's second-quarter activities. We remain committed to elevating stakeholder voices through active engagement, including on calls like this one. As a reminder, our Coverage to Care initiative offers resources for consumers and partners in up to 10 languages to help people understand health care coverage and stay connected to regular care. Our recently updated Partner Toolkit includes a Roadmap to Better Care, Roadmap to Behavioral Health, Prevention Flyers, and more -- prepared in both English and Spanish. And in the spirit of all-hands-on-deck that you heard Dan mention, we are also bringing information about Medicaid eligibility renewals to our Coverage to Care partners.
Specifically, with respect to Medicaid eligibility renewals, we're sharing outreach strategy and amplifying messages to help reach medically underserved populations that we know often are at increased risk of coverage loss. That includes grassroots efforts and direct community events and conferences, organizational partnerships, and through a variety of media and communication outlets.

As you have heard Principal Deputy Administrator Blum mention at the top of the call, a major highlight of the last quarter was also the inaugural CMS Health Equity Conference. We hosted that conference at Howard University in early June, intentionally to create a space for health equity leaders from across CMS, the Department of Health and Human Services, and really the entire health care system to come together. Topics addressed at the conference ranged from maternal health, behavioral health, tribal health, inclusive and accessible care for people with disabilities, LGBTQ+ health, oral health, diabetes prevention and care, the social determinants of health, health-related social needs, health literacy, language access, quality measurement, diverse and inclusive health workforce, the impact of COVID-19, the power and perils of data and AI, the importance of community partnership, and lifting up voices of people with lived experience. Briefly, by the numbers, we had 500 people in person at Howard, and over 1,000 people joined virtually, eight federal agencies were represented in dozens of sessions featuring 60 speakers.

I would like to highlight a few of the themes that we heard because they really underscore what we hope to continue in this work together. The Assistant Secretary for Health, Admiral Rachel Levine, highlighted key areas where we can address disparities to advance health equity, including climate change, LGBTQ+ health, sickle cell disease, and long COVID. Dr. Hayes-Dixon, Dean of the Howard University College of Medicine, emphasized the importance of supporting diversity and representation in the health care workforce. Dr. Benjamin Smith from the Indian Health Service highlighted the importance of acknowledging historical injustices and social determinants of health and the need to partner with diverse communities to address health disparities. And last but not least, we heard from Mayor Stephen Benjamin, the Senior Advisor to President Biden and Director of the White House Office of Public Engagement, who highlighted the White House Challenge to End Hunger and Build Healthy Communities—both focused on reducing disease and disparities. Most importantly, we know that this work does not end with the conference. We will continue this conversation by sharing key messages of the conference and continuing to champion the important health equity work happening across the country alongside many of you on this call. I look forward to our continued partnership in embedding a sustainable culture of health equity within the healthcare system. Thank you again. I will now turn it over to my colleague Dara Corrigan.

Dara Corrigan: Thank you so much. My name is Dara Corrigan—I am the Deputy Administrator and Director for the Center for Program Integrity, or as we call it, CPI. And today, I am happy to highlight some of our second-quarter accomplishments. As I mentioned during the last call, the Biden-Harris Administration is committed to improving the quality of care in the nation's nursing homes, including by increasing the transparency of ownership information. We've taken steps to provide more transparency and require more from nursing homes and other providers such as hospitals, home health agencies, and hospices so that they will disclose to us private equity company and real estate investment trust ownership interests. Building on existing nursing home ownership information that we released in September of last year, we also took steps in June to make the data available on Nursing Home Care Compare that will identify groups of nursing homes linked together by common owners and operators referred to as affiliated entities. This will give us the insight into the amount we are paying for nursing home care and the quality of that care. As I mentioned during our last call, we did issue a Nursing Home Disclosure proposed rule in February. The rule and changes to our enrollment form will require nursing homes to publicly disclose the details of every direct and indirect owner that

oversees, manages, or operates a nursing home. We are currently reviewing the comments that we have received on the proposed rule.

I would like to turn to another vulnerability that I touched on last quarter. Late last year, there was press coverage, congressional interest, and stakeholder interest regarding rapid enrollment of potentially fraudulent hospices in four states: Arizona, California, Nevada, and Texas—some of which appeared not even to be operating at their listed address. We worked really hard to develop a program integrity strategy aimed at better addressing potentially fraudulent hospices on the front end before they enroll, or very closely after they enroll, in the Medicare program. As part of the strategy, we are conducting hospice site visits, where we actually go to the places again. We are implementing a provisional period of enhanced oversight, where we will conduct a pre-payment medical review in those four states for newly enrolled hospices. We will also initiate a medical review pilot project to review hospice claims immediately following an individual's first 90 days of hospice care. We are also proposing regulatory changes that were suggested by the hospice industry. These changes include moving hospices to a high-risk enrollment screening. It will prohibit the sale or transfer of a hospice for 36 months, and it will require additional disclosures about ownership on enrollment applications. Our goal, ultimately, from the beginning to the end, is to make sure hospices are treating Medicare beneficiaries in the right way and for the right reasons. They are there to provide critical quality end-of-life care for beneficiaries.

CMS is also committed to combating fraud across all of its programs, including the Marketplace. CPI has the responsibility for conducting in-depth investigations of agents and brokers using data analytics and listening to consumer complaints. If we identify potential fraud or abuse, we can suspend or terminate an agent or broker's ability to enroll consumers in the Marketplace. In June of 2023, CPI issued seven suspensions based upon the reasonable suspicion that an agent or a broker may have engaged in fraud or abusive conduct. We have already terminated two of those agent brokers.

Finally, I want to mention COVID-19 over-the-counter tests. Consistent with the Administration’s strategy to provide easy-to-use, at-home COVID-19 tests free of charge during the pandemic, CMS implemented an Over-the-Counter COVID-19 Test Demonstration. While the Demonstration itself ended on May 11, claims can still be submitted for one year. What we found towards the end of the PHE is that beneficiary test complaints skyrocketed, and we identified instances of providers who started billing for an unusually high volume of test kits. We took immediate action to hold payments for COVID-19 over-the-counter test kits, and we have implemented over 100 provider payment suspensions to date. We continue to work and to look into complaints and investigate instances of abuse of the Demonstration. This includes working closely with law enforcement partners on these and other fraud schemes related to the COVID-19 pandemic that exploited our programs.

I thank you very much for listening today. It is great to have the opportunity to speak to so many people at one time. I will turn the call back over to Eden, who will move us into the Q&A period. Thank you very much.

Eden Tesfaye: Thank you so much, Dara, and many thanks to all of our other speakers. As I noted earlier, we solicited questions, and we will be walking through those questions now. Our first question is for the Center for Medicaid Director, Dan Tsai. Dan, what can health plans, providers, and advocates do to ensure people with Medicaid or CHIP stay covered now that regular Medicaid renewals have begun?

Dan Tsai: Very good question, I will start by saying thank you to the broader community who have been engaged and advocates who have been highly engaged with us and feeding us specific examples and concerns and things for us at CMS to follow up on. With that said, many of us mentioned the all-hands-on-deck piece. I think we see low awareness, amongst most of our Medicaid enrollees, of what's happening. So number one, for plans providers and advocates, really helping to make sure folks are aware, and our message is simple: one, update your contact information; two, when you get your form open and return it, three, if you're a parent and you know you are not eligible, please still return your form, because your kids might very well still maintain eligibility, and if you don't return the form they will lose coverage. Fourth, if you do lose coverage and are not eligible, go to HealthCare.gov, the ACA Marketplace, and you very well might be eligible for highly subsidized coverage. So, overall messaging, and I think for plans and providers in particular, we are looking for continued partnership with health plans, we have asked and given states numerous policy options. So, really use plans and direct outreach to help people fill out applications to make it through the process. So, thank you for what folks have been doing, and we are continuing to ask people and lean in to do everything possible. Thank you.

Eden Tesfaye: Thank you, Dan. My next question is for the Center for Medicaid Director, Dr. Meena Seshamani. How have recent rules improved access to critical behavioral health services, particularly for people with Medicare? And as a follow-up to that question, how can stakeholders continue to ensure counselors have a smooth transition into the Medicare program?

Dr. Meena Seshamani: Thank you so much for that question, Eden. The short answer is yes, we are improving access here. In the Physician Fee Schedule, we proposed to allow marriage and family therapists and mental health counselors, including addiction counselors, to enroll in Medicare and bill for their services for the first time ever. They will be able to enroll in Medicare if we finalize this provision in the final rule. So, I encourage everybody to comment on the proposed rule. If we finalize this proposal, it will be so important for us to work with all of you so we can get the word out that these new types of providers can enroll in the Medicare program, so we can let people in Medicare know that they can go to one of these providers for their behavioral health services.

Eden Tesfaye: Thank you, Meena. We appreciate that detailed response. The next question is for the Acting Director of the Office of Minority Health, Dr. Aditi Mallick. How is CMS addressing data accessibility for minority health research?

Dr. Aditi Mallick: Thank you for the question, Eden. We know this is a really important area and often one that is cost-prohibitive. On June 29, our office released a new notice of funding opportunity, or NOFO, for the Health Equity Data Access Program, or HEDAP. It supports up to three seats for up to three years in the CMS Virtual Research Data Center (VRDC), and for folks

that don't know, those seats can be upwards of $90,000. So, the HEDAP assists researchers from public and state-controlled or private institutions of higher education in gaining access to otherwise restricted CMS data for the purpose of minority health research. The NOFO can be found on grants.gov, and the opportunity number, if you have a pen handy or you want to scribble this into your cell phone, is CMS-2L2-23-001, and we can make that information available after the call as well. The deadline to submit applications is Tuesday, August 15, at 3:00 PM Eastern time. We really strongly encourage you to apply and share with your networks. This is an important opportunity to get access to data to perform health service research that focuses on but not limited to racial and ethnic minority populations, individuals with disabilities, members of the LBGTQ+ community, individuals with limited English proficiency, individuals living in rural areas, or any individuals and communities adversely affected by persistent poverty or inequality. Thank you so much.

Eden Tesfaye: Thank you, Dr. Mallick. Our next and final question is for the Center of Medicare and Medicaid Innovation Deputy Director Ellen Lukens. How has CMMI prioritized working more closely with safety net providers? Can you talk more about how the Making Care Primary, or MCP, model will recruit community health centers and why they might be interested in participating?

Ellen Lukens: Sure, I would be happy to. So, Making Care Primary builds on previous Innovation Center models, including CPC, CPC+, and Primary Care First model, which were designed to support primary care clinicians. But this one really focuses explicitly on making advanced primary care widely accessible by making it possible for a more comprehensive group of participants to participate in the model, including Federally Qualified Health Centers. A key difference is that MCP provides an on-ramp to value-based care for primary care providers who are new to value-based care arrangements or would like to participate in value-based care arrangements independently. Specifically, the characteristics of MCP that may make it attractive to community health centers include that it provides upfront infrastructure payments directly to eligible providers. It will also adjust payments to reflect the complexity of populations, and it will also provide opportunities for providers to be rewarded directly for delivering positive outcomes for their patients. Thanks again for the question.

Eden Tesfaye: Thank you, Ellen. Well folks, that wraps up the Q&A portion of the call. I want to thank all of the speakers today and everyone who has joined us and for your continued partnership on all CMS programs and initiatives. As a friendly reminder, we are conducting these calls quarterly. Please keep an eye out for the invitation to our next quarterly call. With that, it is my honor to turn it over to our Principal Deputy Administrator, Jon Blum, for closing remarks. Jon over to you.

Jon Blum: Thank you Eden, and thanks to the whole team here, and thanks for those who have joined us today. As you have heard, we have done a lot in the past quarter. But that work has been shaped and informed and really made possible the stakeholder feedback. CMS will continue to do that through the formal processes, meaning that we encourage and really ask you to continue to comment on the rules and policies, etc. But these kinds of forums give us the chance to get better information and feedback, and that will continue. We've made tremendous progress in our strategic plan, and we see great things for our programs and even better things for those

covered by our programs. With that, we will stop here. Thank you again for joining us, we can't wait to see you next time on the next quarterly call. Thanks again.