Centers for Medicare & Medicaid Services
Quarterly National Stakeholder Call with CMS Administrator
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Eden Tesfaye: Thank you all so much for joining us today for our fourth and final Centers for Medicare and Medicaid Services National Stakeholder Call for 2023. I'm going to walk through today's agenda and then turn things over to our speakers. But before I do that, I have a couple of housekeeping items for folks. 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 the Media Inquiries Form, which may be found at cms.gov/newsroom/media-inquiries. We will not be accepting live questions during the call. However, we did solicit some questions beforehand, and we will answer a few of those today. Everyone should be able to see today's agenda on their screen. We have a full agenda that includes the CMS Administrator, Chiquita Brooks-LaSure, and her leadership team, providing 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, it's my honor to turn it over to our leader, Administrator Chiquita Brooks-LaSure. Turning it over to you, Administrator.

Chiquita Brooks-LaSure: Thank you so much, Eden. And as Eden said, it's so amazing that we're almost through the year and that this is, in fact, the last of our stakeholder sessions for this year, and I hope you all find them helpful. I always marvel every time we do this, just how much has happened since the last time we gathered. It's my favorite time of the year as we get ready for the holiday season. Those of us on the East Coast feel the chill in the air as it feels like fall really came in full force this weekend. A couple of weeks ago, I was in Kansas City, and I get the sense that a lot of us in America care a lot more about football than maybe we have in the past. So, just wishing you all a very nice fall.

But for us here at CMS, fall often means the start of our busiest season. And that's because so many of the people who rely on our programs and the three Ms are in the process of going through an open enrollment season. As you know, we kicked off open enrollment for the Medicare program on Sunday, and it's always a tremendous time as we remind seniors and people with disabilities who depend on the Medicare program that it's important to take a look at one's options because our health needs change over the course of each year, and, as you know, there are so many robust options that are available, both in Medicare Advantage as well as our Part D programs. We've made some efforts this year to really help strengthen the ability of people who rely on the Medicare program to navigate our website and to be educated about their options. And I want to just call out a couple of our important policies that you all have given us input on that we have really focused on during this year's open enrollment.

One, of course, is just making sure that people know what they are entitled to and what benefits they will have if they enter into an arrangement in Medicare Advantage, Part D, or traditional

Medicare. And, as you all know, we have really focused on making sure that we're strengthening our marketing practices, and so those are some changes that will hopefully be noticeable both to Medicare beneficiaries and for all of our stakeholders over this open enrollment.

There's so much to say about the Inflation Reduction Act and how it directly is going to impact the people who depend on Medicare, which is so many of our nation's seniors and people with disabilities, and there are tremendous benefits that really take place in 2024, and we're working hard, working with all of you to educate people about those options. As you know, those with high costs for their prescription drugs will, for the first time ever, have a catastrophic limit in 2024, and we continue to encourage people to enroll in Medicare Savings Programs and the Low-Income Subsidy (LIS). So, you'll see more emphasis on that in this year's open enrollment, and we just urge all of our partners to help get the word out about how people can enroll in those programs because they are very effective for seniors and people with disabilities to enroll and those who have modest incomes to enroll in that coverage. I also want to highlight that our second M, Marketplace Open Enrollment, will begin in just a couple of weeks, which we are also gearing towards. Marketplace Open Enrollment is a tremendous time for people to enroll in Affordable Care Act coverage, which, thanks to recent legislation and the support of the President, is more affordable than ever, but it's also a time for people who are maybe not eligible for Marketplace coverage to think about their options, and, as you know, we are very much in the Medicaid renewal process where we're encouraging people to make sure they've updated their data, to reach out to their states, and we are working very hard with states and partners like you to make sure that people get re-enrolled into Medicaid or enroll in other coverage if they are eligible for that.

And then, finally, before I turn it over to our next speakers here at CMS, I want to encourage all of us to renew our vaccines. Thanks to so much legislation, vaccines that are recommended by the CDC, so many of them are available at no cost, and we all know that this is the time of year to make sure we're up to date on our flu vaccines, our COVID vaccines, and for those who are over age 60 to consider getting the RSV vaccine. So, with that, I'll turn it over to Jon Blum, to go through some more updates here at CMS. Jon?

Jonathan Blum: Great, thank you so much. I just wanted to share four points here, really from the operational perspective. We are managing CMS through a comprehensive strategic plan. That plan has six pillars that drive work and 13 cross-cutting projects, and each center, each office that you'll hear more about today, has their own plan that ties to one CMS plan. We track more than 400 measures throughout CMS and we are very pleased to say that our strategy and our plan is very much on track. And you'll hear more details today regarding each center, each office that is driving work throughout the agency that really builds on the CMS strategy and much better coverage and much better care for those that are covered by CMS programs.

I want to just share just three numbers that summarize well the quieter work that the agency does to ensure that the programs work well. The first number being 642, the second number being 3290, and the third number being 7.9 billion. The first number 642. We have added new staff to CMS, 642 fantastic folks that have joined CMS during the past 12 months. That's roughly 10% to the overall workforce here. CMS continues to hire, continues to attract phenomenal talent coming to the agency, and though we have slowed down hiring somewhat, due to uncertainty

caused by the overall fiscal situation, CMS will continue to hire. And to those that are thinking about CMS as a part of their careers, there is no better time to join this fantastic team here. The second number 3290. We have made more than 3,000 separate contract awards during the past fiscal year. That is a huge accomplishment for our team. It just shows that there is so much work that's happening here throughout the agency. There were more than 3,000 contract actions, some close to $8 billion, a 12-time record for CMS. So, just the hiring and the contracting that we're doing just demonstrates that there is phenomenal work taking place here. But the second point, just to emphasize, we just heard about, we have entered a new phase for how CMS covers, pays for, vaccines, testing, and coverage. Those things were covered previously by the federal government, and they have shifted now towards the commercial market, providing those services through the traditional channels. That means that payers like CMS, but also private payers, had to change their systems to ensure that the reimbursement flows smoothly. We are very pleased to say that for CMS, that transition is seamless. There is no reason not to get covered, not to get vaccinated right now. We are also working very, very closely with the payers, providers, and pharmacists to ensure that any friction that we could hear about gets solved very quickly. So that is firmly in place, and we are pleased to say that that transition has gone very smoothly.

The third point just to raise today is that we continue to be very concerned regarding cybersecurity. And those that do contract with CMS, those that do work with CMS, those that touch CMS data, that we are going to be even more vigilant going forward to ensure that we have strong protections in place, we have strong security requirements in place. So, something more to look forward to for those that contract with CMS is much more guidance, much more focus, much more technical support to ensure that we're doing everything we can to ensure safety and management about protecting information. So, that's more to come from CMS. The last thing I'll say is, we are also watching the news very carefully to ensure that CMS is prepared to handle any potential—again, we'll say potential—partial government shutdown. Folks that follow CMS programs should continue to follow CMS news, CMS listservs, and the CMS website for any further guidance that we may have to put out to ensure we're prepared, and that we're doing everything that we can to continue benefits during a potential partial government shutdown. So, with that, I will close. I am really pleased to say that the CMS strategy is on track, and we have never done more than we are doing today. We are really excited for the rest of our speakers to share their great news. With that, we will turn to the next speaker. I believe Meena, you're up next.

Dr. Meena Seshamani: Thank you, Jon, and thanks to all of you for being here today. I'm Dr. Meena Seshamani, Deputy Administrator and Director of the Center for Medicare. As the Administrator mentioned, Medicare Open Enrollment has begun. Open enrollment, as you know, is a perfect time for people with Medicare to evaluate their options. They can make changes to their health plan, or prescription drug plan, they can return to original Medicare, also referred to as Medicare Part A and B, and they can pick a Medicare Advantage plan. Medicare remains strong and stable. Improvements to the Medicare program are adding up to real savings for people, including expanding eligibility thresholds for the Part D Low Income Subsidy, starting in 2024, and improving access to affordable treatments because of the Inflation Reduction Act. Here are a few more examples. As you know, for people who have Medicare and are taking insulin, they will not pay more than $35 for a month supply of each covered insulin product. This includes people who have Medicare drug coverage Part D and all Part B covered insulins. People

with Medicare drug coverage will also pay nothing out of pocket for recommended vaccines, including the shingles vaccine. This includes all vaccines that are recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. And in 2024, people enrolled in Part D who have very high drug costs will get some relief. Once they reach a certain threshold on paying out-of-pocket costs, what we call the catastrophic phase, they will no longer have additional cost sharing or co-pays at the pharmacy. So, we appreciate your help in getting the word out to people with Medicare who can benefit from all of these changes.

With that, the team has continued to be hard at work implementing the other provisions of Inflation Reduction Act. Announcing the list of drugs selected for the Medicare Drug Price Negotiation Program is a significant and historic moment for the American people. CMS will negotiate in good faith on behalf of people with Medicare. And a critical part of the negotiation process is making sure the patient experience and needs of people with Medicare is a key focus. That is why we have set up patient-focused listening sessions, one for each of the selected drugs between October 30 and November 15. These sessions, which will be open to the public and live streamed on cms.gov, will provide an opportunity for patients, beneficiaries, caregivers, consumer and patient organizations, and other interested parties to share relevant input to drugs selected for the first round of negotiations. These listening sessions build on what CMS has been doing since the law's passage to make sure we are implementing the law thoughtfully and transparently. Your input to date has been crucial. Whether that's through responses to documents, coming in to meet with us, or participating in the upcoming listening sessions. Together, we are making Medicare stronger.

Another way we are strengthening Medicare is through our value-based care initiatives. We recently announced that the Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Programs saved Medicare $1.8 billion in 2022, the sixth consecutive year the program generated overall savings in high-quality performance results. It is also the second-highest annual savings accrued for Medicare since the program's inception more than a decade ago. When an Accountable Care Organization participating in the program succeeds, it means that people with Medicare are getting the right care at the right time while avoiding unnecessary services and medical errors. It also means that people with Medicare are getting a better experience, including lower out-of-pocket health care costs. We are encouraged and inspired by our participants and look forward to continually improving and growing the program. So, thank you again for joining us today, and I will now turn it over to Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight. Ellen?

Dr. Ellen Montz: Thank you Meena, and good afternoon and good morning to folks out there. It is lovely to be here. Here at HealthCare.gov, we are looking forward to this year's open enrollment, our eleventh open enrollment beginning November 1 and running through January 15. We are better positioned than ever before for what is sure to be a successful season with a combination of robust, easy-to-understand plan options, an improved customer experience, large-scale outreach, advertising and enrollment assistance, and continued record affordability thanks to the Inflation Reduction Act. You all have done so much to connect folks across the country to this critical health care coverage, and I have every faith in you that doing so again will continue to produce the historic gains we have seen over the past two years—gains that translate into

coverage, translate into health, and translate into better lives, so thank you. This open enrollment comes in the middle of our ongoing top priority, ensuring individuals no longer eligible for Medicaid and CHIP and eligible for Marketplace get signed up for Marketplace coverage as soon as possible. For folks losing Medicaid and CHIP, open enrollment essentially continues well into 2024, thanks to our Special Enrollment Period (SEP) and our ongoing investments in open enrollment style outreach, advertising, and assistance. Our doors are open, and we are excited to see folks continue to make successful transitions from Medicaid and CHIP to the Marketplace coverage.

In addition to a focus on ensuring individuals across the country are connected to the coverage they need and deserve, we are also focused on strengthening consumer protections across the commercial health insurance market. On July 7, we released a proposed rule on short-term limited-duration insurance, which if finalized, would ensure that insurance plans that do not provide the protections of the Affordable Care Act are limited to their intended scope and are transparent to consumers who are shopping for coverage. These proposed changes would support the goals of the Affordable Care Act by increasing access to affordable and comprehensive coverage, strengthening health insurance markets, and promoting consumer understanding of coverage options. We also recently released, along with our colleagues at the Department of Treasury and Labor, a proposed rule on mental health parity, which if finalized would strengthen protections of the mental health parity law that already exist and ensure that mental and behavioral health are provided at parity with physical services within health insurance plans.

Finally, we at CCIIO and the Departments of Labor and the Treasury continue to release guidance related to the implementation of the No Surprises Act. As you know, the enactment of the No Surprises Act has led to the protection of millions of consumers from surprise medical bills—an incredible achievement. Since the enactment of this landmark law, we have been working to establish and refine the new independent dispute resolution process so that payers, health insurance plans, and providers can swiftly and efficiently determine the appropriate payment amount for out-of-network services all without involving patients—the number one goal. The departments are committed to implementing the No Surprises Act in a way that promotes affordability and transparency in the health care system for patients and families, and we will continue to do so. I will now turn it over to Dan Tsai, our Deputy Administrator and Director of the Center for Medicaid and CHIP Services. Dan?

Dan Tsai: Thanks, Ellen. Thanks, everybody for being with us and for your continued interest, support, advocacy, and, in many cases, direct work on the ground with the folks we serve, not only for Medicaid and CHIP but for many other programs. I'm just going to hit on a few things. One, what continues to be the highest immediate priority for us at here at Medicaid and CHIP is Medicaid renewals, and that certainly is not exclusive to Medicaid. We are partnering closely with Ellen and team for Marketplace and many others as we think about our Administration priority of really maintaining coverage for people. Coverage means Medicaid and CHIP for folks who are eligible, for Marketplace coverage, for employer-sponsored coverage, and for a range of things we know people are eligible for, will be eligible for, and are transitioning to, and we want to help them successfully transition to. So, coverage across programs is the number one goal, and we continue to have, at this moment, roughly 90 million people still enrolled in Medicaid and CHIP, which is about 20 million people above where we were in February of 2020, pre-

pandemic. As folks who have been engaged with us day-to-day have heard—and we are pretty sure there are some of you that spend dozens of hours each week engaged on policy matters, on outreach, on the work on the ground, on care provision, and on health plans doing all sorts of things as well, so thank you—a few things we emphasize: one, we take our compliance and oversight role extremely seriously here at the federal level. We are certainly engaging and partnering with states across a range of pieces, and we are also ensuring that's consistent with the statute; we are holding states accountable to following the federal requirements, at minimum, the federal requirements for Medicaid renewals. That really has involved close monitoring and oversight and identifying when we find issues of compliance, working with the state to have them pause their procedural disenrollments, to have them pull individuals by reinstating people that have inappropriately lost coverage and by continuing to pause until they are able to fix the issues. So there have been a range of those, and the most notable has been, across the country, has been identifying the issue with the way a number of states, about 30 states, were conducting auto-renewals, which are required by Medicaid regulations. They are really common sense, state Medicaid programs being able to use data available to the state to help renew someone successfully without having to send a paper form, and if the data indicated that we found a glitch, that impacts about half a million kids and others, and all those states have been really hard at work reinstating coverage, making fixes, that has been a huge focus of the recent work of the Center with states. So, compliance, oversight, and making sure states are following the minimal regulations has been a really big piece. The other component has been supporting and encouraging and providing opportunities to go far above and beyond those minimums. So, I think many of you know we have approved about 300 waivers or policy options that make the Medicaid renewal and CHIP renewal process easier and more streamlined with less red tape involved. That includes everything from using a kid's enrollment in SNAP to help auto-renew kids and keep them connected to coverage to being able to utilize Managed Care Organizations (MCOs) more to a range of other pieces. So, we continue to work with states to maximize flexibilities in the context of making the Medicaid and CHIP renewal process easier and to help people successfully get over to Marketplace and employer-sponsored coverage, of which we are seeing early indicators that it's happening, and that is exciting. It is all hands on deck, and we continue to ask for and appreciate and look for help, support, feedback, and intel on the ground on what is happening. And there are states that have pulled out all the stops alongside us as well, and we deeply appreciate that, so that continues to be a huge area of focus.

Second, I just wanted to note—very exciting—that North Carolina is expanding Medicaid after many years of work. We have been excited to partner alongside the state to see where they have gotten to, and our teams have been supporting on anything the state needs to make sure Medicaid expansion successfully launches, and that is an exciting priority. Third, continuous eligibility for kids. Many of you know that Unwinding has really highlighted the challenges [inaudible] that happen, the ways in which the renewal process for Medicaid and CHIP really is sometimes cumbersome to get through even if a state is following the federal requirements. Federal statute now requires all states to have kids continuously enrolled for at least 12 months starting 1/1/2024. We've spent a lot of time working with our state colleagues, getting ready for that, and putting out guidance. That is an exciting piece, and as folks know there's a number of states for whom we have approved continuous eligibility for kids up to the age of six, and we anticipate a number of other states with requests for that in the winds. Finally, we have spoken about rulemaking, where we have a range of groundbreaking rules on the street. The team is actively

reviewing comments for access, managed care eligibility and pharmacy, things that are really important and got a lot of comments. The team looks forward to finishing review of those and finalizing. So, thank you all for your engagement and support, and with that, I will turn to Arrah at CMMI. Thank you all.

Arrah Tabe-Bedward: Thank you, Dan, and Administrator Brooks-LaSure. And thanks to all of you for taking the time to be here with us today. I'm excited to be able to share updates from the Innovation Center. On July 31, we announced our second model of the summer, the Guiding and Improved Dementia Experience Model, or GUIDE Model. Dementia can be a devastating diagnosis, and we know that people living with dementia, and their caregivers as well, often struggle to manage their health care and connect with key supports that allow them to remain in their homes and communities. The current system of care for people with dementia is fragmented and siloed. GUIDE seeks to address these challenges and has three primary goals: improve the quality of life for people with dementia, reduce strain on their unpaid caregivers, and help people to remain in their homes and communities longer—by preventing or delaying long-term nursing home placement. In this voluntary, nationwide model, participants will establish dementia care programs that provide ongoing, longitudinal care and support to people living with dementia through an interdisciplinary team. GUIDE is unique because it acknowledges and addresses the critical role that caregivers play in the lives, health, and outcomes of people living with dementia. It is also the first model to target reductions in federal spending on long-term nursing home placement, a metric that is not only important to achieving federal savings but also a key person-centered indicator of quality improvement. Please keep an eye out for the Request for Applications for the GUIDE Model later this fall.

In addition to announcing the GUIDE Model, on September 5, we announced the States Advancing All-Payer Health Equity Approaches and Development Model, or our AHEAD Model. AHEAD proposes a significant restructure of health care spending across all payers in a state or sub-state region, with increased investments in the types of care better correlated with improved population health and health equity, like primary care, which are offset by reductions in spending and utilization in other areas in order to constrain total cost of care growth. This is a very ambitious model, and it combines elements and lessons learned from the Vermont All-Payer ACO (Accountable Care Organization) Model, the Maryland Total Cost of Care Model (MTCOC), and the Pennsylvania Rural Health Model (PRHM). The model is also an important component of advancing our strategy and vision of whole health system transformation and transformation sustainability. As part of the model, participating states commit to set targets for improving Medicare fee-for-service in all-payer cost growth, in primary care investment, and statewide quality and equity. These targets are important components of the AHEAD Model, but the model is also designed to be flexible enough to meet states where they are and support ongoing transformation efforts. Funding is available for up to eight states or regions, and we anticipate releasing a Notice of Funding Opportunity later this fall.

And the last thing that I'll mention is that, over the summer, the Innovation Center opened a comment period through a Request for Information, to gather input on a future episode-based payment model. The comment period has now closed, and we're working through the comments that we received. In general, we heard excitement around our commitment to continue accountability for episodes of care. The long-term commitment is essential to ensure the

continued investment in episode-based care, and we plan to use this feedback to better understand how to support and encourage specialist engagement and participation in future models. And we'd like to thank everyone who provided feedback to us as part of this process. I will stop here, and just say thanks again for being here today. And stay tuned for more information on new models that we hope to announce in 2023. And with that, I will turn it over to Dr. Mallick.

Dr. Aditi Mallick: Thank you, Arrah. My name is Dr. Aditi Mallick. I'm the Acting Director of the CMS Office of Minority Health (OMH). It's a privilege to join you today to be able to share a bit about our office's recent activities.

First, in recognition of September as National Sickle Cell Awareness Month, our team released the CMS Sickle Cell Disease (SCD) Action Plan. We recognize that there are unique challenges faced by individuals living with sickle cell disease, and the action plan outlines CMS's efforts to reduce health disparities and improve health outcomes for everyone impacted by sickle cell disease. Specifically, the action plan focuses on four key areas: one, expanding coverage and access; two, improving quality along the continuum of care; three, advancing equity and engagement, and four, examining data and analytics. I encourage you to check it out on the CMS OMH website.

Second, I want to re-emphasize our commitment to building the Capacity of Health Care Organizations and the Workforce to Reduce Health Care Disparities. And I'll highlight two specific examples of that. First is, we recently awarded the Minority Research Grant Program (MRGP). These are awards that go to three minority-serving institutions to support research that examines critical public health disparities. The research for this year's awardees focuses on maternal child health, re-entry of incarcerated individuals, and connecting kids to coverage—all themes that we've explored on today's call and in prior calls. The specific grantees are Morgan State University, the University of New Mexico Health Sciences Center, and California State University San Marcos Corporation. More details about those awardees can also be found on our website.

In addition to the Minority Research Grant Program, our office has also supported health equity and research via the Health Equity Data Access Program, or HEDAP. This is a grant program where three recipients receive funding to access seats in the CMS Virtual Data Center, data that would otherwise be CMS restricted. And the purpose of that research is really focused on minority health. Each grantee receives funding for three years of data access, to conduct research projects that focus on specific minority and underserved populations. This year's grantees are the George Washington University, University of Kansas Medical Center Research Institute, and the University of Missouri System.

The last thing I want to highlight is our partnership with the CMS Office of Communications, with an eye towards advancing language access and increasing awareness of Medicaid renewals—which I know you heard about earlier on this call. It was specifically through a paid media plan to add a focus on additional languages in key populations via radio ads. Those languages include Chinese, Hindi, Korean, Tagalog, and Vietnamese, in states including Texas, New Jersey, Florida, Pennsylvania, Minnesota, Nevada, California, New York, Washington,

Illinois, Virginia, Massachusetts, Hawaii, Maryland, Arkansas, and Georgia. These radio ads were designed to encourage affected consumers to take action to update their contact information, complete renewal forms, and visit the Marketplace at HealthCare.gov, to look for other coverage options as applicable. This last quarter really allowed us to financially support a culture of health equity outside of CMS and to look internally and continue to address the needs of enrollees in CMS programs. We know that in order for these efforts to be durable and sustainable, we need your partnership. So, thank you for being here today, and thank you for your ongoing partnership. With that, I will now turn it over to my colleague, Dara Corrigan, in the Center for Program Integrity (CPI).

Dara Corrigan: Hi, good afternoon or good morning, folks. It's really nice to see you. And thanks for the introduction, Dr. Mallick. My name is Dara Corrigan. I'm the Deputy Administrator and Director for the Center for Program Integrity, or CPI. I am here today to talk a little bit about what we've been able to accomplish in the third quarter, and many of these are some updates on what we've been doing throughout the year that's been of particular interest, and we're particularly proud of the accomplishments in these areas. The first is an update on the program integrity aspects of the COVID-19 over-the-counter (OTC) test Medicare demonstration. We're very happy to report that complaints regarding these tests, and whether or not people requested them or received them, have decreased dramatically. While the COVID over-the-counter test demonstration ended on May 11, towards the end of the Public Health Emergency, complaints increased dramatically from beneficiaries who received tests that they said that they didn't order. At the same time, we identified instances of providers who started billing for an unusually high volume of tests.

We took immediate action, in this last quarter, to hold all payments for COVID-19 over-the-counter tests on June 22, 2023. And we also implemented approximately 150 provider payment suspensions. A payment suspension is exactly what it sounds like. We stop paying while we investigate. We've since released some payments for these tests when they were legitimate, but we've put additional safeguards in place, and edits in place to help prevent inappropriate payments. We continue to look into complaints, and we would appreciate it if you continue to report any problems that you're experiencing with these tests. We will investigate those instances of abuse, and we will work with our law enforcement partners closely on these, and any other fraud schemes related to the COVID-19 pandemic.

Second, I'd like to provide an update on another vulnerability that I've mentioned previously, which is fraud by hospice providers. Late last year, there was press coverage and congressional interest in four particular states—Arizona, California, Nevada, and Texas—where an unusually high number of hospices were enrolling in the program. And what we did was, we went and looked at all of that data, which we really appreciated. It helped us to focus and really think through our program integrity strategy. And as part of that strategy, we decided to conduct a nationwide hospice site visit program, which means we actually went out to every Medicare enrolled hospice. We visited, as of October 11, about 6,700 hospices across the country, and nearly 450 of those hospices are being considered for potential deactivation or revocation of their Medicare billing privileges. While some of these hospices may be able to demonstrate compliance by submitting a valid address or other items that are missing, others that do not address our findings will be deactivated or revoked. Our goal is to make sure that hospices are in

the program for the right reasons—to provide critical, quality end-of-life care to our Medicare beneficiaries, and we are working directly with stakeholders to ensure that we are supporting hospices that are doing the right thing. Last month I had the opportunity to personally meet with a large group of non-profit hospices, and it was one of the most productive conversations I've had in a long time. I mean, it was really a back-and-forth about, what do you do with a program that is so critical, but at the same time, has a lot of people who are trying to defraud the program? And I look—very much—look forward to meeting with more stakeholders about this issue, and how we can address the problems and really have high-quality hospice care.

Switching gears very quickly from Medicare to Medicaid. You've heard about this already, a lot today from the Administrator and from Dan Tsai, but there are processes that Medicaid enrollees would normally go through to renew their coverage that were put on pause. As we've stated before, we are continuing to work through that process with every available resource that we have, but CMS will not hesitate to hold states accountable if we determine that they are not adhering to federal renewal requirements. And we are very much hoping that we get through this period in a way that has integrity and really, really helps the people who benefit from our programs. And with that, I am happy to turn it over to my colleague, Dr. Dora Hughes.

Dr. Dora Hughes: Thank you. Thank you, Dara, and good afternoon. I am Dora Hughes, Acting CMS Chief Medical Officer and Acting Director of the Center for Clinical Standards & Quality (CCSQ). As Administrator Brooks-LaSure mentioned, on September 1, we issued a proposed rule, which would establish comprehensive nurse staffing standards for long-term care facilities. This proposal aims to hold nursing homes accountable for providing safe and high-quality care to the over 1.2 million residents they serve. We took a multi-faceted approach to help inform our proposals. This included conducting a new staffing study, reviewing over 3,000 comments from last year's Request for Information, hosting listening sessions, analyzing Payroll-Based Journal and survey data, examining existing state standards, and reviewing the literature. Our proposals reflect all the available evidence.

The proposed rule consists of three core staffing proposals: first, minimum nurse staffing standards for Registered Nurses and Nurse's Aides; a requirement to have a Registered Nurse on site 24 hours a day, seven days a week, and third, updates to the existing facility assessment requirements. We believe that our staffing proposals are balanced and achievable. They would help advance safe, quality care for residents, while also striking an appropriate balance that considers the current challenges some nursing homes are experiencing, particularly in rural areas. Again, this is a proposed rule. We encourage everyone to comment by the November 6 deadline. We expect that public comment and any additional evidence will help to inform our final approach.

Another update for CCSQ—on June 22, we announced a proposed procedural notice outlining a new Medicare coverage pathway, the Transitional Coverage for Emerging Technologies pathway—known as TCET. TCET is intended to: first, facilitate early, predictable, and safe beneficiary access to new technologies; second, reduce innovators' uncertainty about coverage by evaluating the potential benefits and harms of technologies early; and third, encourage evidence development if evidence gaps exist. The TCET pathway uses current national coverage determination and coverage with evidence development processes to expedite Medicare coverage

of certain Breakthrough Devices. In addition to the proposed TCET procedural notice, CMS issued a proposed, updated Coverage with Evidence Development guidance document and a proposed Evidence Review guidance document. We also issued the first in a series of guidance documents that review our current thinking on health outcomes within priority therapeutic areas. We believe these documents offer insight into how CMS reviews clinical evidence and gives transparency into Coverage with Evidence Development. The public comment period for these documents closed in late August, and we greatly appreciate the comments and information that interested parties have shared with us. We are working diligently to review the comments, and we'll respond to them when we finalize the documents.

The next update that I will briefly mention—on September 15, the Organ Transplantation Affinity Group, also called OTAG, led by CMS and the Health Resources and Services Administration, or HRSA, announced a bold action plan aimed at driving improvements in donations, clinical outcomes, systems improvement, quality measurement, transparency, and regulatory oversight of our nation's organ transplantation system.

And as a final update, both yesterday and continuing today—October 16 and 17, the Consensus-Based Entity, now through Battelle's Partnership for Quality Measurement, is meeting in-person in Baltimore to provide an orientation to members and to conduct the Measure Set Review for the End Stage Renal Disease (ESRD) Program. This is the first in-person meeting with the new CMS contractor for the Consensus-Based Entity, which transitioned to Battelle in March earlier this year. As you may know, the Consensus-Based Entity is authorized by statute to provide review, recommendations, and endorsement for quality measures used in multiple CMS value-based programs. And so, concluding these updates, I'm going to turn the mic over to Kerry Branick, Deputy Director of the Federal Coordinated Health Care Office (FCHCO). Thank you.

Kerry Branick: Thank you, Dr. Hughes. Last month, we issued a final rule to simplify eligibility for Medicare Savings Programs (MSP). Medicare Savings Programs are Medicaid eligibility groups through which Medicaid covers Medicare Parts A and B premiums, and often cost-sharing. And about 10 million people are in the Medicare Savings Programs today. These programs make Medicare affordable. They help people who may not otherwise be able to afford monthly premiums or costs-sharing for things like going to the doctor. The Medicare Savings Programs also reduces out-of-pocket costs for prescription drugs. Enrollment in these programs automatically deems Medicare beneficiaries into the Part D Low Income Subsidy (LIS), or Extra Help.

Unfortunately, researchers estimate that only about half of eligible individuals are enrolled in Medicare Savings Programs. And that means that millions of people are living in poverty—that are living in poverty—are paying over 10% of their income to cover Medicare premiums alone. So, why do so many people miss out on Medicare Savings Programs enrollment? One of the reasons is that the eligibility and enrollment process is very complicated—even for people who are highly likely or even certain to be eligible based on receipt of other program benefits. And our new rule does a lot to improve access. As you likely know, Supplemental Security Income, or SSI, is a federal benefit for people who have little or no income and resources. SSI provides monthly payments to older adults and people with disabilities, many of whom have Medicare. And all people on Medicare who receive SSI are financially eligible for the most comprehensive

Medicare Savings Program eligibility group. It's called the Qualified Medicare Beneficiary, or QMB group, and that covers Medicare premiums and cost-sharing. Many states require a separate application for QMB, even after the individual qualifies for SSI. And our final rule eliminates that extra application and requires most states to enroll SSI recipients into QMB. As a result, we estimate almost 300,000 Medicare beneficiaries on SSI will newly gain access to QMB Medicare premium and cost-sharing assistance. The new rule also better aligns that Extra Help program and the MSP, which means less need for people to provide the same information when they apply for both programs. It reduces paperwork that is part of those application processes but also maintains program integrity safeguards.

Finally, we aligned the definition of family size for Medicare Savings Programs to be no more restrictive than the definition for LIS or Extra Help, and that definition is broader, and includes relatives in the same household. And so, this policy especially helps grandparents raising grandchildren and other multi-generational families. Together, these provisions will improve access to care and economic security for over 860,000 low-income older adults and persons with disabilities. Thank you, and I will turn the call to Dr. Chalmers.

Dr. Natalia Chalmers: Thank you, Kerry. Greetings, all. My name is Natalia Chalmers, and I'm the Chief Dental Officer here at CMS. Over the past two years, CMS has made significant strides in advancing oral health. We are excited to announce the launch of the Oral Health Cross-Cutting Initiative (Oral Health CCI), which is focused on expanding access to oral health coverage across all our programs—Medicaid, CHIP (Children's Health Insurance Program), Medicare and Marketplace. Under the Oral Health Cross-Cutting Initiative, we aim to partner with states, health plans, and health care providers to improve access to oral health services and leverage our authority to expand care. We are working to ensure that beneficiaries and consumers can access oral health services that promote overall health and wellness.

Here are just a few highlights of our program work. In Medicaid, we completed a two-year quality improvement learning collaborative to advance oral health prevention in primary care, benefiting many Medicaid beneficiaries. Today, all 50 states and DC (District of Columbia) have decided to offer dental coverage for Medicaid enrollees who are pregnant or postpartum for at least 60 days after pregnancy. In addition, a mandatory reporting of oral health-related measures is in the Child Core Set—and will begin in 2024, emphasizing oral exams, fluoride application, and dental sealants. And we've also initiated a strategic planning process for the next five years of our Medicaid and CHIP Oral Health Initiative, gathering stakeholder feedback. Thank you to all those who participated.

Another very important area of Oral Health Data-Driven Evidence-Based Policy Analytics—we've enhanced oral health analytics, and made these resources available to the public, including data on utilization of preventive services by Medicare beneficiaries, as well as Medicaid adult beneficiaries' emergency department visits for non-traumatic dental conditions, and many more. Oral health was also featured in multiple sessions during the 2023 CMS Quality Conference and the first-ever CMS Health Equity Conference.

In Marketplace, following the No Surprises Act, we hosted an overview webinar with over 250 dental providers to clarify its provisions.

In our customer engagement rule, we conducted oral health human-centered design research in four states, interviewing close to 100 individuals to understand barriers to oral health access for Medicaid and dually-eligible beneficiaries that would inform our policy. And in Medicare, we codified that Medicare payment under Parts A and B could be made when dental services are furnished in association with specific covered medical treatment, in both inpatient and outpatient settings. We also established a process to review public recommendations for Medicare payments for dental services linked to certain covered medical services. And in this year's rule, we proposed codifying payment policies for dental services for head and neck cancer treatments and expanding payment for certain dental services linked to cancer-related treatments.

These changes will ensure access to dental services for Medicaid, Medicare, and Marketplace beneficiaries. We are committed to promoting oral health as an integral component of overall well-being and look forward to further progress in this area. Thank you for your attention, and we appreciate your continued support in advancing oral health across all of our programs. I will turn the call back to Eden, who will move us to the question-and-answer session for today's call. Eden?

Eden Tesfaye: Thank you so much. Unfortunately, we are at time, and so we will not be able to proceed with the question-and-answer portion of the call, but we'll definitely get to it for the next National Stakeholder Call. And with that, that wraps up today's CMS updates for this call. I want to thank all of our speakers today and thank everybody who joined across the country for 2023's last National Stakeholder Call. We're conducting these calls quarterly, so please keep an eye out for the invitation to our next quarterly call for 2024. With that, I'd like to turn it back over to Administrator Brooks-LaSure for closing comments. Administrator, over to you.

Chiquita Brooks-LaSure: Thanks again, Eden. And as you can hear from all of our presenters, there is a great deal of work here being done at CMS, and we know that we cannot do anything without all of you. So, let me end this discussion by thanking all of you for your work, whether you are an advocate working on behalf of the people who are served by the three Ms; whether you are a provider, system, health plan, or to so many of the stakeholders that help us achieve what we all want, which is for people to achieve their optimal health. So, thank you. Thank you for all of your work across the country and your partnership with us, and we hope you enjoy the rest of the day.